THE RESPONSE OF THE ANGLICAN CHURCH OF KENYA IN THE FIGHT AGAINST HIV/AIDS: AN ASSESSMENT OF THE ALL SAINTS DIOCESE, NAIROBI, KENYA

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A project paper submitted in partial fulfillment of the requirements for the award of a Master of Arts Degree in Rural Sociology and Community Development, Department of Sociology, University of Nairobi.

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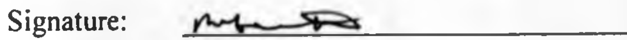

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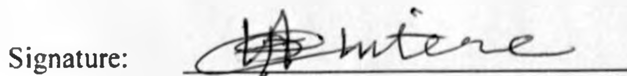

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DEDICATION

This Project paper is dedicated to my husband, Philip and our little girl Rebecca for their encouragement and support during my studies and for enduring the long hours of my absence as I undertook this project.

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The findings, interpretations and conclusions of this report are entirely those of the author who solely is responsible for any error(s) or omission(s).

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ABBREVIATIONS

CAPA	Council of Anglican Provinces of Africa
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
ACK	Anglican Church of Kenya
ICASA	International Conference on AIDS and Sexually Transmitted Infections in Africa
KAMA	Kenya Anglican Men's Association
KAYA	Kenya Anglican Youth Association
MU	Mother's Union
TOT	Training of Trainers
PLWHA	People Living with HIV/AIDS
PCC	Parish Council Committee
VCT	Voluntary Counseling and Testing
WCC	World council of Churches
ASC	All Saints Cathedral
SLK	St. Luke's Kenyatta
HTK	Holly Trinity Kibera
SFK	St. Francis Karen
SJK	St. Joseph Kabete
CKN	Christ the King Ngando

ABSTRACT

This project paper is entitled "The response of the Anglican church of Kenya in the fight against HIV/AIDS: an assessment of the All Saints Diocese, Nairobi, Kenya". Today HIV/AIDS presents the single most important health and socio-economic challenge in post independence Kenya. Kenya has about 1.9 million people living with HIV/AIDS; hence one of the hardest hit countries in sub Sahara Africa. For a long time, many of the people infected have suffered psychologically, socially and economically as reflected in the problem statement. It is upon this scenario that many development partners inter alia the church, the government, NGOS came up with programmes to fight the disease. However, with these efforts, the pandemic still is rampant.

It is upon this backdrop that the study, sought to examine the various responses especially those initiated by the Anglican Church in the fight against HIV/AIDS. Specifically this research project examined in detail the operational activities of the Anglican Church of Kenya under the All Saints Cathedral Diocese in the fight against the scourge. Among the programme activities run by the church include; community orphan care; support of people living with and personally affected by HIV/AIDS, prevention activities, pastoral care and support, and outreach programs.

To find out whether the goals of these programmes are realized the study set three objectives, one, to identify the challenges facing the ACK intervention efforts and its capacity to deal with these challenges. Secondly, to evaluate the effectiveness and sustainability of HIV/AIDS Church initiated programmes and finally to establish the members perceptions of the programmes.

The methodology employed by this study was participatory, which involved members of selected parishes in the diocese as case studies. The researcher used both snowball and purposeful sampling techniques to select her respondents. In getting members for the focused group discussion the researcher used the snowball sampling method, where the first member in the group helped identify the second and the procedure was used to gather all members in all the sample size groups. Through purposeful sampling the researcher managed to identify those in leadership and also involved in the programme activities for the interviews. All the focus group interviews were done

on specific days when most members were free. In this case the researcher collected the qualitative data using focus group discussion guide.

Some of the findings of the study include, one, there is little knowledge about the HIV/AIDS desks at provincial and diocesan level. Two, some of the programmes initiated in the parishes, include counseling, HIV education and prevention, outreach services, orphan support, referral for HIV testing, spiritual counseling, bereavement support for families and awareness creation. Three, challenges faced by the church include, information flow to all levels, inadequate finances, the big size of the diocese, the diversity of communities in the diocese, ownership of the programme, stigma, lack of dedication, lack of qualified personnel, lack of initiative by the clergy and lack of an inter ministerial pool. Four, consequences of the challenges outlined, which include increased numbers of people getting infected as well as socio-economic implications. Five, contribution of members namely MU and KAMA to the fight against HIV/AIDS in the diocese. Six, member's perceptions towards the interventions and seven, the effectiveness and sustainability of the diocesan interventions strongly depends on ownership, good will by members and leaders, continued flow of funds through the set church structures and enhancement of volunteerism.

The study has recommended that several steps needs to be taken by the diocese in order to effectively make an impact in the fight against HIV/AIDS. Some of the recommendations include setting up of parish HIV/AIDS committee comprising of all the church groups namely; Sunday school, youth, MU, clergy and KAMA, which will in turn mainstream HIV/AIDS in their respective fields.

The study has however concluded that, the diocese has made little or no impact in the 6 parishes assessed in its fight against HIV/AIDS due to the absence of impact at the grass roots level as well as the full participation of members in the assessment, planning, design and implementation of the current activities. A major set back identified by the study is the lack of HIV/AIDS policies at diocesan and parish levels as well as an HIV/AIDS strategic plan at the provincial and diocesan level. Therefore, the efficiency and sustainability of current and future interventions depends on the levels of ownership, willingness by members and leaders, availability

of funds and community mobilisation in eradicating stigma and discrimination in order to have more people going for HIV/AIDS tests and hence preventing further spread of the virus that causes AIDS.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Since the first time AIDS cases were clinically diagnosed and reported in 1984, the HIV infection rate has risen to the level of a world pandemic. The steady increase of the illness has become a serious health and developmental problem in many regions around the world affecting both developed and developing countries. Every day about 15000 people become infected with HIV, the virus that causes AIDS.

According to the WHO global programme on AIDS (WHO/GPA) by mid 1995,estimated that there were 20 million HIV infections in the world. This figure is composed of 18.5 million adults and 1.5 million Children. The joint UN programme on AIDS (UNAIDS) estimated that by the end of 1998 about 14 million people had already died of AIDS while another 33.4 million people were estimated to have been infected with HIV (Ncozana 2000).

Africa has got its own share of the problem since the AIDS scourge continues to threaten many lives across the continent. In sub-Sahara Africa today, 28.5 million adults and children are estimated to be living with HIV or AIDS. This region continues to have the highest figures of infected people compared to other parts of the world. According to (UNAIDS, 2002), Sub-Sahara Africa is home to 70% of the adults and 80% of the children living with HIV in the world.

Aluku (2002) observes that, every segment of African society today is under attack from the AIDS pandemic. It is estimated that over 28 million people are infected with the virus in sub-Saharan Africa alone. The southern African countries have been identified as the most affected, with the Republic of South Africa having more infected people than any other country in the world. But even in the face of such terrifying statistics, the attention paid by most African governments to the debilitating effects of the HIV/AIDS pandemic is insufficient.

According to the International Labor Office, the economic impact of HIV/AIDS in sub-Sahara Africa is far more severe than previously thought and will seriously undermine the development prospects of African countries. The ILO reports that across all occupational sectors in sub-Saharan Africa, it is becoming increasingly difficult to replace skilled as well as unskilled labor lost to HIV/AIDS.

The epidemic is eroding the capacity for development through its effects on labor supplies, savings rates, national security and social cohesion. Furthermore, health care and education will be affected directly by the same problems of replacing lost labor and skills that afflict other sectors.

AIDS is preventing both men and women from providing their full contribution to development, from maintaining the structure of families and from sustaining productive capacity over the longer term.

The epidemic is also eroding the savings capacity of households, formal and informal enterprises and governments through its direct effects on flows of income and levels of expenditure. Over time this will lead to falling demand, reduced investment and output and declining per capita income. In the public sector overall mortality in some countries has risen by 10 times over the past decade largely due to AIDS and is likely to result in governments losing the ability to supply essential goods and services.

In Botswana, the increased mortality rate of healthcare workers is reducing the capacity to meet higher demands for care for people with HIV and AIDS. Among police officers in Malawi, the epidemic is having a severe impact on junior officers aged 20 to 40. In the informal sector, which in most African societies accounts for the majority of workers, studies in Kenya and Cote d'Ivoire found that sickness and mortality due to AIDS has resulted in the dramatic depletion of savings, the loss of key skills and organizational capacity and a fall of up to 50 per cent in food production in households.

The 2002 UNAIDS report indicates that an estimated 14 million children who have lost either one parent or both due to AIDS are living across the globe. Out of this figure approximately 80% - 11 million are in sub Saharan Africa. It is estimated that

by 2010, in five countries of eastern and Southern Africa, over 30 percent of all children under age fifteen will be orphans, largely due to AIDS, according to the Census Bureau, Hunter and Williamson (2000:20). Many of these Sub Saharan African countries are under siege by an orphan crisis that will not be adequately addressed by the construction of more orphanages.

The numbers are too high and the need for care is too great. It is important to note that the overwhelming majority, certainly over 90 percent for the children orphaned by AIDS in the most affected countries, live within their extended family and community; a fundamental response must be to strengthen the capacities of families and communities to protect and care for their children.

1.1.2 Background of the HIV/AIDS scourge in Kenya

In Kenya, HIV/AIDS was first recognized in 1984. Due to under reporting, missed diagnosis and delays in reporting, it was estimated that by 1997 the number of AIDS cases reported in one year were on average 12,000 since 1990. (GOK 1997) According to the 2002 UNAIDS report, it was revealed that by the end of 2001, Kenya had a prevalence rate of 15% of the people infected with HIV/AIDS.

It took the government 15 years since the first case of AIDS was recorded in Kenya to understand the devastating effects of HIV/AIDS and the required courage to set Kenya on a path of Action. On 25th November 1999, the former head of state declared HIV/AIDS a national disaster and called upon the citizens of Kenya to fight for a common cause in dealing with the scourge (Kenya National AIDS strategic Plan 2000 – 2005).

He said;

...AIDS is not just a serious threat to our social and economic development, it is a real threat to our very existence...AIDS has reduced many families to the status of beggars...no family in Kenya remains untouched by the suffering and death caused by AIDS... the real solution of the spread of AIDS lies with each and everyone of us.

The interventions that followed after the denial period can be divided into three phases; the government action, community action and a joint government and civil

society action. In response to the government call, the church had to chip in against this fight.

The government of Kenya according to NASCOP (2001) took up the lead role in financial, human and technical resources to combat the pandemic. In the first step the government issued Sessional paper Number 4 of 1997 as the framework for its response to the pandemic. The sessional paper stresses the need for a strong political commitment at the highest level, implementation of a multisectoral prevention and control strategy. The government thus went further to establish the National AIDS control council (NACC) in November 1999 to guide the HIV/AIDS initiative in the country.

The government embarked on promoting the AB and C. The idea is to practice abstinence for the unmarried and being faithful to one partner for the married couples and the availability and use of condoms for sexually active people. What followed were a series of events that saw the establishment of voluntary and counseling centers (VCT), PMTCT programmes and rigorous campaigns by the NARC government under the motto "Pamoja Tuangamize ukimwi".

The church (community of Christians) was asked by the government to be one of the Key members to the National AIDS advisory Committee. The national AIDS committee was established in 1985 to advice the government on all matters related to the prevention and control of AIDS. Initial church response was slow, hampered by the prevalent doctrine and thinking that HIV/AIDS was a curse from God. This we see as the example of a church in denial.

However when HIV/AIDS was first talked about, the church and especially the leadership thought that AIDS was a problem for the prostitutes, the promiscuous, the drug and substance abusers and many others and that the 'righteous' church had nothing to do with it. This mistaken view based on ignorance at the time cost the church and the country a lot of time and lives. Unfortunately, some churches have never outgrown that view. They still talk about AIDS patients as "them" and they point fingers to some people they think are "high risk" and therefore prone to HIV infection.

In partnership with international agencies and local NGO's, the government is working towards the control of the HIV/AIDS scourge in Kenya. The joint government and civil society action can be placed under the new initiative by the NARC government to bring on board all sectors of the society in the fight against HIV/AIDS. The decentralization of the NACC to focus on constituency level initiatives is one such action that could lead to an enhanced multi sectoral approach in the fight against AIDS.

Non-governmental organizations emerged to collaborate with the government in the fight against stigma, discrimination and violence against women. It is recorded that a higher percentage of women and girls in Kenya are infected. According to UNAIDS (2002), it was estimated that out of the 2.2 million infected Kenyans, 1.4 million were women.

1.1.3 Involvement of the Anglican Church of Kenya in the fight against HIV/AIDS

According to Dortzbach, (1998) the Church plays a very active role in every part of Kenyan society. In this context, the church can be understood to mean either as the church buildings made of Cathedral – cut stone, mud – packed walls, or churches with no walls at all throughout the country side in Kenya and call people to worship regularly. The authors further state that there are many churches in Kenya, of all types and denominations, which are estimated to have 80% of their members being churchgoers. The large denominations are the Catholic, Anglican, the Africa Inland church and Presbyterian denominations.

The above argument can be supported by the records obtained from the Anglican Church of Kenya whose following is now estimated to be over 5 million people in all parts of this country. This is a denomination of people who have embraced the teaching of the gospel of Jesus Christ, as part and parcel of addressing physical, social and economic needs of humanity in a holistic ministry since inception. Although the ACK was among the very first institutions to get involved in the fight against HIV and AIDS at the beginning of the 90's but it did not have a clear policy framework on the scourge and its participation was very weak. Its major strength lies in the church's mission and vision statements against the HIV fight.

In the last seven years the Anglican Church of Kenya (ACK) has mobilized communities and congregation against the HIV/AIDS scourge, which has posed a serious threat to families and humanity at large. Meetings and seminars have been organized to increase the awareness of people on the spread and dangers posed by HIV/AIDS. Discussions on causes, coping mechanisms and its prevention have also been part and parcel of consultations, workshops and information sharing.

The church's development outreach through the Christian Community Services (CCS) empowers poor people and other needy community members to live a fulfilled live as exemplified in the bible by integrating strategies for enhanced standards of living and capacity building to restore hope, dignity and salvation to those in the bondage of sin, hopelessness and despair. But it is not clear how far the members have involved themselves in these programmes.

1.2.0 STATEMENT OF THE PROBLEM

The HIV/AIDS epidemic in Kenya began in the 1980s. Although the first case was diagnosed in 1984, the virus was gradually spreading among the population through either sex, blood transfusion or from mother to child. HIV/AIDS is now common among those aged between 15-49 years of age. This is the age category, which is sexually active. The National AIDS and STD Control programme (NASCOP) reported that by the year 2000, there were 1.9 million people already infected with HIV. Most people with HIV look healthy, majority do not know that they have HIV unless they have HIV blood test. Many others have died.

HIV/AIDS is a serious medical and psychological problem. Those infected develop poor health and spend a lot of money seeking health care services. More than half of the beds in our local health facilities are occupied by patients suffering from HIV related illnesses. When people get to know that they are sero positive, they emotionally respond differently. Some get shocked and develop mental problems. Worse still, others suffer the social stigma meted out by the society against them in the form of discrimination. With this glaring situation in our society the government together with other stakeholders such as; WHO, NGOs, CBOs, FBOs and individuals

came up with an ally of interventional programmes aimed at reducing and controlling the HIV/AIDS pandemic.

The programmes which were initiated by the government to fight HIV/AIDS were educational campaigns aimed at creating awareness on HIV, promoting the use condoms, home-based care, counseling services, blood screening, The church among the Faith Based Organizations (FBO's), based on its moral obligation to the community had to intervene in the fight against HIV. The initial response by the church was slow and a majority in the church leadership viewed HIV/AIDS as a curse from God against those who are immoral. This mistaken view based on the church leadership made the country loose many lives. Unfortunately, some church leaders and their followers have never outgrown this view. It is not clear how well equipped is the ACK to meet the challenges of the disease.

However many people have continued to look to the church for spiritual knowledge, guidance and direction in their fight against HIV and above all repentance. The church is in a unique position to address both the spiritual and non spiritual needs of the people infected and affected by HIV/AIDS. Due to the numbers of people living with HIV/AIDS and dying due to AIDS relates deaths, the church as a moral authority was forced to come up with a modality of dealing with HIV issues in a more focused way. Therefore, in 1997, the Provincial HIV/AIDS department of the Anglican Church of Kenya was launched. Through this department, the HIV/AIDS programme was integrated in the development programmes of the dioceses as well as pastoral activities. Although the programmes were put in place, there is no evaluation study, which has been done to show the achievements and failures of the interventions.

It is worth noting that Anglican Church efforts against the spread of HIV infections in neighbouring Uganda have proved a success and this can be attributed to the fact that people are now informed and are aware of HIV/AIDS. However, this is far from reality in Kenya. The church has several challenges ahead, namely the increasing numbers of orphans as a result of one or both of the parents dying from AIDS and the sub sequent food insecurity and psychological trauma for the orphans can explain the magnitude of the problem.

The increasing cases of stigma, which have resulted in horrific forms of discrimination and violence even rejection, ridicule and death itself. Disaggregating the impact of AIDS requires detailed and concrete examinations of specific sub Saharan settings. In particular, the linkage between HIV/AIDS and the stigma and discrimination patterns of religious groups and communities on the national and provincial level merits fuller exploration than it has received to date.

Other challenge facing the ACK are the large numbers of church leaders who are not aware of the modes of transmission of HIV, the absence of theological reflections in the area of HIV/AIDS as well as the absence of good models are areas that need to be addressed. The people's perceptions of programmes such as HBC (home base care) and pastoral care need to be evaluated. Above all the low numbers of people going for voluntary counselling and testing to know their HIV status and the challenges of setting up diocesan AIDS desks through out the 29 dioceses of the Anglican Church in Kenya are also areas of concern. With this glaring situation one wonders how holistic are the church HIV/AIDS programme activities and their durability. The study was therefore guided by the following research questions: -

Research Questions

1. What is the ACKs' capacity in tackling the challenges of HIV/AIDS?

   Under this section, the study attempted to highlight the general views of members about the challenges facing the Anglican Church in its interventions programmes at Diocesan and Parish level. The study also attempted to assess the capacity of the Church in the Diocese of All saints in line with challenges the Church faces as it implements or plans to put in place HIV/AIDS interventions in the designated study parishes.

2. How effective and sustainable are the ACK strategies for fighting HIV/AIDS?

   Given the numbers of people currently living with HIV/AIDS in Kenya and the increasing numbers of orphans, the reality of sustaining the HIV/AIDS programmes by the Anglican Church is quite a challenge. The study attempted to

review the efficiency of the ACK HIV/AIDS interventions and how the programmes can be sustained. The specific objective of this research question was to establish whether the members were and are aware about the implementation activities of the HIV/AIDS programmes initiated by ACK at Provincial/diocesan and parish level.

3. What are the perceptions of the members towards the HIV/AIDS programmes initiated by the ACK?

This question aimed at getting the respondents views regarding the activities or projects already in place or those in the pipeline in the All Saints diocese and the specific Parishes under study. The responses of the members to the programme were also addressed.

1.2.1 JUSTIFICATION OF THE STUDY

It was noted during the search for literature in line with this study that there continues to be insufficient literature documenting the response of the church especially that of the ACK in reducing the spread of HIV in Kenya. The study by WCC (1997) dealt with the impact of HIV/AIDS in the society but never addressed the issues of capacity of the church in the fight against HIV/AIDS and their effectiveness. The study left out some unique issues related to the church. The issues related to the nature, perception and success were not adequately addressed. The Anglican churches' response does not articulate the issues raised in this study. Neither does the study conducted by MAP international (2001) in process of developing the HIV and AIDS curriculum for theological Institutions and Bible Colleges Across Africa.

It is evident that church leaders and members are eager to act, but the little that they do could be going un noticed due to lack of documentation in this area. After attending a regional workshop for Provincial secretaries and Provincial AIDS coordinators organized by the Council of Anglican Provinces of Africa – CAPA in Mukono, Uganda (January – February 2003) the Head (The Archbishop) of the ACK

announced the launch of an independent HIV/AIDS programme at National level. Since its launch, no official strategy to combat HIV/AIDS has been launched.

The ACK churches are very much concerned with the HIV/AIDS pandemic and this is witnessed by the number of orphans, widows and infected people whom the church assists. Although the programme was launched at a national level, we are not sure whether the affiliate churches have the capacity to wage this war successfully. Therefore the study was compelled to look at the various existing structures found in the churches and how helpful they are in campaign against the disease.

To date, Christian's responses to the HIV/AIDS programme have not been assessed. The study therefore attempted to establish the capacity of the church in handling HIV/AIDS issues. By so doing the study was able to identify the successes and failures of the programme and also its acceptability as well as assess the sustainability of the programme and its activities. The information obtained shall be used by the institutions concerned to revitalize and reinforce the programmes on the ground towards success.

It is estimated that 2.2 million Kenyans were infected with HIV/AIDS by the end of 2001. It is also estimated that out of every eight adults in rural Kenya one is infected. The statistics are worse for the urban areas where nearly one out of every five adults is infected. According to National AIDS Control Council (2002), Nairobi Province, the area under study had 175,000 HIV positive people in the age group 15 – 49 years, in the year ending 2001. Nairobi's prevalence rate is second in the country to that of Nyanza province with 22% - 480,000 HIV positive people as of 2001. Nairobi is an urban area, which has a well-served communication network, and has more well funded NGOs and FBO's dealing with HIV/AIDS issues. A majority of the residents are elites who are well informed about the HIV/AIDS scourge. But with all these one wonders why the HIV/AIDS programmes cannot pick and also help reduce the prevalence rates.

The results of this study shall contribute to the field of community development and that of medical sociology, especially to what others have done on HIV/AIDS. Hopefully the study findings shall be used by other scholars for future references and also to identify research gaps for further research as well as form the basis for future

interventions by the Anglican Church in enhancing their HIV and AIDS prevention and control programmes.

1.3.0 OBJECTIVES OF THE STUDY

The study aims at pointing some of the set backs of the ACK HIV/AIDS programme as well as its strengths. It also highlights the possible responses that the church can take up in empowering communities and the clergy in strategizing to curb the AIDS crisis. The general objective of the study was to examine the response of the Anglican Church of Kenya in the fight against HIV/AIDS. This was achieved by focusing on the strategic programmes used by the church to combat the spread of the epidemic in Nairobi. The study was predominantly descriptive and mainly aimed at documenting the activities being conducted by the All Saints diocese.

To be able to achieve the above broad objectives, the study focused on the following specific objectives: -

1. To examine ACK's capacity to tackle the challenges of HIV/AIDS.

2. To evaluate the effectiveness and sustainability of the HIV/AIDS programmes initiated by ACK.

3. To establish the member's perceptions towards the HIV/AIDS programmes initiated by ACK.

1.4.0 SCOPE AND LIMITATIONS OF THE STUDY

The geographical scope of the study covered only the Anglican Diocese of All Saints. This diocese composed of six parishes is found within an urban setup. The All Saints diocese region stretches from Nairobi's city centre to Kajiado in the southwest. The Diocese and parishes outside this geographical area were not considered for this study

The respondents covered were drawn from among the parishioners of the diocese as well as community members receiving services from the church programmes. These include those in administration of the parish and the supportive staff such as the clergy, AIDS coordinators, counselors, laity, who formed part of the target population. On the other hand church group members such KAMA and MU involved in the interviews were those from the parishes comprising the Diocese and were actively involved in the HIV/AIDS programmes. Those church community members not directly associated with the programme activities are not regarded in this study. The majority of the respondents in the FGD's were the leaders of their groups drawn from the various parishes understudy, this therefore, did not include other members who might have held different opinions from those of the group leaders.

Also similar programmes carried out in the same region either by other non- ACK churches or NGOs' were not considered for the study. All the data collected was targeting the specific aspects of programme management. Other aspects outside this scope were disregarded. The findings of this study can only apply to categories and subjects who have similar characteristics as this sample size. Further, the study focus was limited to strategies of the Anglican Church in responding to the AIDS crisis.

1.5.0 DEFINITIONS OF KEY CONCEPTS

Affected a term used for the family, friends and other persons associated with someone living with HIV or AIDS

AIDS (Acquired immune deficiency Syndrome) multiple signs and symptoms or a combination of diseases caused by the Human immunodeficiency virus (HIV), which weakens the body ability to fight infections, making it especially vulnerable to opportunistic infections (STI's). The study thus makes a difference between AIDS and HIV (refer to the definition of HIV below)

Care and support These are based on an active concern for the well being of others and ourselves. People directly affected by HIV/AIDS need care. People living with HIV/AIDS, their families and communities are also involved.

Counselling This is the process of helping those in dilemma understand their situation. This involves encouraging the person counseled to be bold and brave and look at the problem at hand positively

Effectiveness This is used to refer to the progress and achievements made by the HIV preventive and control strategies. This includes people's acceptability of the programme ideologies.

HIV (Human Immunodeficiency virus) the virus that can eventually cause AIDS. People infected with HIV may look and feel well for a number of years before any opportunistic infections develop. Many people infected with the HIV virus are completely unaware of the fact, unless they decide to have a medical blood test. However, they can be carriers of the virus, transmitting it to other people

HIV – Positive (or seropositive) a term indicating that the HIV anti body test on a person has indicated the presence of antibodies in the blood. If the test is positive, it means that the person has been exposed to HIV and that his or her immune system has developed antibodies to the virus.

Infected A term used for a person who has the HIV virus within his or her body.

Pastoral care This is a term used to refer to the type of spiritual care provided by the pastor. The care given is the form of guidance, giving hope, seeking redemption and material support includes the roles of the church members to the community, giving hope to the sick etc

Perception The people's view about the disease and how they regard the approaches used in the fight against HIV/AIDS

Prevention This encompasses the various efforts (abstinence, faithfulness, uphold morals and using other precautionary measures) against contracting the illness.

Strategies This refers to the interventions or approaches initiated by the church to fight the challenges of the AIDS pandemic.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.0 Introduction

This chapter critically analyses literature about HIV/AIDS interventions. It has therefore been organized under the following themes; AIDS transmissions in the world, AIDS as a Social Problem; Challenges of the Church in Africa, The All Africa Anglican AIDS initiative, ACK initiative and the theoretical frameworks

2.1.0 AIDS transmission in the world

The first time AIDS was found on a large scale was among male homosexuals in America and it was described as the "gay plague", the gay cancer and also the gay related immunodeficiency (Weelings, 1988:24, Weeks 1989b: 4). Information about AIDS begun to appear in journals and other mass media but the causes of the illness was still unknown. Later it was revealed that AIDS could also be transmitted heterosexually.

In the mass media and popular opinion, AIDS has been transformed into a global health problem of unprecedented magnitude with a daunting potential impact (Bennet: 1988, Fleming: 1988). The situation has crystallised intense feelings and polarized social relations (Herzlich and Pierret, 1989, King 1989.). While the situation prevails, the authors are assuming that almost every body is aware of the impact of the disease in the society. There are some places, where through the mass media many have been informed and are quite aware of the dangers and fatality of the disease, but there is still no behaviour change and this needs to be addressed. This suggests that information alone, whether scaring or not is not enough.

Since the disease came to the fore in 1981, more than 60 million people have been infected with the virus, around 20 million of whom have died. In the year 2003, through out the world 40 million people were estimated to be living with HIV; 5 million people were newly infected; 3 million died of AIDS. It is observed by WHO (2002) that more than 90% of all infected persons live in developing countries. It is clear that the illness is spread so rapidly and the rate of infection outweighs the rate of

dying. We are not clear of the socio-economic implication of the scourge with this big number of people infected with the disease. It is alleged that most of the infected people are living in the developing world and they will die there, but why is there a big disparity between the developing and the developed world.

The disease according to Mwonya et al (2001) is mainly transmitted through known ways (un protected sex, mother to child through breast milk or at birth; blood transfusion and unsterelised body piercing objects) and can be avoided through easy precautionary measures for instance through abstinence or the correct use of condoms. It is rather perturbing to realize that the illness is transmitted through known ways, which can be avoided easily. But there is no mention of the success witnessed where these preventive measures have been applied in the past and their weakness.

Despite lack of a cure, AIDS can be managed with available biomedical technology, and with considerable relief to the affected person (Plummer, 1988). In this regard, AIDS is not peculiarly different from other form of cancer, which have no known cure, but are manageable. Because of the fear that the illness carries this has made its social management extremely difficult. This has therefore accelerated the prevalence rates of the virus in Sub Saharan Africa.

Plummer (1988) has blamed stigma as the social challenge against the management of the illness. Does it mean that stigma is the only problem hindering the management of the disease? If stigma was to be managed and people continue with their risky behaviour patterns, could it help in contributing to the elimination of the illness. People stigmatise and disassociate with those who are known to be infected but still associate with those who are not known and assume facially that they are safe. As indicated in the table below, HIV transmission varies from region to region.

Table 1. Modes of HIV transmission in Africa and in industrialized countries

HIV Transmission	**in Africa (in %)**	**In industrialized countries**
Mother to child	10%	<1 %
Blood transfusion	2%	0 %
Homosexual	0%	39
IV drug use	1 %	37
Heterosexual	87 %	24

Source: AIDS: meeting the challenge, WCC 2004

Table 2. Global data for 2003 for adults and children (UNAIDS 2003)

Further, the table below shows the prevalence levels globally

Region	HIV Infection	Prevalence	AIDS deaths	New infections
Global	40 Million (34-46M)	1.1% (0.9-1.3%)	3 Million (2.5-3.3M)	5 Million (4.2-5.8M)
Sub Saharan Africa	25.0-28.2M	7.5-8.5%	2.2-2.4M	3.0-3.4M
Northern Africa & Middle east	470,000-730,000	0.2-0.4%	35,000-590,000	43,000-67,000
South Asia & Southeast Asia	4.6-8.2M	0.4-0.8%	330,000-590,000	610,000-1M
East Asia & Pacific	700,000-1.3M	0.1%	32,000-58,000	150,000-270,000
Latin America	1.3-1.9M	0.5-0.7%	49,000-70,000	120,000-180,000
Caribbean	350,000-590,000	1.9-3.1%	30,000-50,000	45,000-80,000
Eastern Europe & Central Asia	1.2-11.8M	0.5-0.9%	23,000-37,000	180,000-280,000
Western Europe	520,000-680,000	0.3%	2,600-3,400	30,000-40,000
North America	790,000-1.2M	0.5-0.7%	12,000-18,000	36,000-54,000
Australia	12,000-18,000	0.1%	<100	700-1,000

HIV/AIDS is unique in human history in its rapid spread, its extent and the depth of its impact. Since the first AIDS case was diagnosed in 1981, the world has struggled to come to grips with its extraordinary dimensions. Early efforts to mount an effective response were fragmented, piecemeal and vastly under-resourced. Few communities recognized the dangers ahead, and even fewer were able to mount an effective response. Now, more than 20 years later, 20 million people are dead and 37.8 million people (range: 34.6–42.3 million) worldwide are living with HIV. AIDS expands relentlessly, destroying people's lives and in many cases seriously damaging the fabric of societies.

The experience has shown that the natural course of the epidemic can be changed with the right combination of leadership and comprehensive action. Two decades of tackling AIDS have yielded important successes and have taught crucial lessons about which approaches work best, although a cure remains elusive. We now know that comprehensive approaches to prevention bring the best results. Forthright national leadership, widespread public awareness and intensive prevention efforts have enabled entire nations to reduce HIV transmission. In Africa, Uganda remains the pre-eminent example of sustained success. In Asia, comprehensive action in Thailand averted some five million HIV infections during the 1990s. Cambodia too has managed to curb rapid growth of its epidemic. On every continent we can point to cities, regions or states where concerted efforts have kept the epidemic at bay.

At the same time, we now have antiretroviral medicines that can prolong life and reduce the physical effects of HIV infection. Coordinated national and international action has slashed the prices of these medicines in low- and middle-income countries, and sustained efforts are now under way to make access a reality for people living with HIV across the world who desperately need antiretroviral therapy. But the antiretroviral are there to prolong life but not as a cure

Though the veil of silence and stigma that has crippled efforts to respond to AIDS is finally lifting in many countries. Leaders of governments, businesses and religious and cultural institutions are increasingly coming forward to take action against AIDS. The movement of people living with HIV has become a global force in the vanguard

of social change in responding to the epidemic. The impact of AIDS on development prospects in the worst affected regions is being increasingly recognized.

Despite these signs of progress, more sophisticated monitoring and evaluation of the epidemic's behaviour reveal the scale of the challenge: fewer than one in five people who need prevention services and tools have access to them. Globally, five to six million people need antiretroviral medicines now; yet only 7% in low- and middle-income countries have access to these drugs—fewer than 400 000 people at the end of 2003. (WHO 2004)

Many national leaders are still in denial about the impact of AIDS on their people and societies. According to the 3x5 initiative and work that has recently been done by WHO to realise the objectives of this strategy and therefore increase access to antiretroviral and eventual universal access to those who need ARVs, certain activities done by WHO have given indication to treatment gaps and the work that needs to be accomplished in order to put 3 million people on ARVs by the end of year 2005.

There is a fair commitment of financial resources to tackle the disease, but it is still less than half of what is really needed. Nzioka et al (2001) held that, even these funds are not being applied in a fully effective, coordinated manner. In some instances, AIDS funding sits idle, but even where the absorptive capacity is present, the funds do not trickle down to the beneficiaries at community levels. The result of this is that the AIDS epidemic is now at a true crossroads. If the world's response to AIDS continues in its well-meaning but haphazard and ineffectual fashion, then the global epidemic will continue to outpace the response.

In the early days of the epidemic, men vastly outnumbered women among people infected with HIV. Indeed, it initially took the medical establishment some time and a great deal of evidence before it accepted the very idea that HIV was a threat to women. The proportion of females infected by HIV worldwide steadily grew until by 2002 about half of all people infected were women and girls. (Mwonya et al 2001).

In Southern Africa, where AIDS has touched almost every family, infected females outnumber males by as much as two to one in some age groups. Besides being the

majority of those infected, women and girls are now bearing the brunt of the epidemic in other ways too: it is they who principally take care of sick people, and they are the most likely to lose jobs, income and schooling. Women may even lose their homes and other assets if they are widowed. To bring the concerns of women and girls into sharp focus, the gender dimensions of treatment needs and its acquisition cannot be left out in any well-meaning intervention.

Besides women, the epidemic is also affecting young people disproportionately: 15–24-year-olds account for half of all new HIV infections worldwide; more than 6000 contract the virus every day. This trend is especially alarming because this is the largest youth generation in history. Today's 15–24-year-olds have never known a world without AIDS, and have no 'folk memory' of the shocking early days of the 'new' disease. Yet it is today's young people who will be responsible for sustaining responses to the epidemic—they are tomorrow's leaders, thinkers and decision-makers, and it is vital that they play an integral part in responding to the epidemic. The only sad part that young people are heavily targeted in prevention intervention, yet a good pool of young people require to be on treatment, but serious considerations have not been given to how, where and when they access treatment.

HIV transmission is not a random event; the surrounding social, economic and political environment profoundly influences the spread of the virus. Wherever people are struggling against adverse conditions, such as poverty, oppression, discrimination and illiteracy, they are especially vulnerable to being infected by HIV. Efforts to prevent the spread of HIV need to focus both on individual risk behaviour, and on the broad structural factors underlying exposure to HIV—so as to help people control the risks they take and thereby protect themselves. Vulnerability, risk and the impact of AIDS coexist in a vicious circle. Vulnerability can be reduced by providing young people with schooling, supporting protective family environments and extending access to health and support services population-wide. (Roberts et al 1996).

Addressing vulnerability at the structural level includes reforming discriminatory laws and policies, monitoring practices and providing legal protections for people living with HIV. In a similar manner the health seeking behaviour, which is crucial in accessing treatment including ARVs, operates in an environment, which is supportive

for both illiterate and literate populations using interventions that are culturally and socially acceptable. The information for both informal and formal systems must be packaged to address as many diverse groups without marginalizing women, young people and other minority groups.

Since 2002, the feasibility of providing antiretroviral therapy in resource-poor settings has become almost universally recognized. Governments and donors worldwide are increasingly committed to expanding access as quickly as possible to the many people who need life-prolonging antiretroviral treatment. Scaling up antiretroviral treatment requires assured long-term political support and funding. Any lapse in support could result in collapsed antiretroviral programmes, with resultant interruptions in treatment giving HIV the opportunity to become drug resistant. Not only would this be an individual tragedy, it would also create a grave social threat, since drug-resistant strains of the virus can spread and render entire treatment programmes useless. (UNAIDS 2002).

Health staffing is also crucial to the prospects of extending antiretroviral access. Already, Africa has a major shortage of nurses, midwives and doctors, as they leave their native countries for better salaries, working conditions and opportunities in higher-income countries. As observed by Panos 1992, Brown 1996:13; the gap is partially filled with health professionals from other African countries, which then widens the gap there. The cycle of out-migration leaves the lowest-income countries on the continent in dire need. It is important to avoid the kind of chaos reported from some countries, where desperate patients buy antiretrovirals without medical advice and often without prescriptions.

Treatment literacy should be an integral part of all treatment programmes, and people with HIV can play an important role since they speak with the authority of their own experience. In addition, community members can be trained to support treatment adherence and can assume some of the duties of health-care workers. This will help make more efficient use of all available resources.

The appropriate information on ARVs including their side effects and what one expects when starting treatment weighed against the benefit must be given before one

makes a choice to start ARVs. This information should among other channels come from a user's perspective and hence the role of PLHWA. The issue of stock-outs and nutritional requirements should be discussed as a part of the intended treatment plan. It should also be a common knowledge to communities who and at what stage one is expected to start treatment with ARVs as not all HIV positive people are in need of ARVs. This literacy should be made as functional as possible.

As part of follow-up activities to the 2001 UN Declaration of Commitment on HIV/AIDS, the UNAIDS Secretariat and Cosponsors collaboratively developed a series of global, regional and national indicators to measure the world's progress in reaching the Declaration's targets. In 2003, 103 Member States of the UN provided UNAIDS with national reports on their progress, which formed the basis of a comprehensive assessment of global, regional and national responses to AIDS. It was called 'Progress report on the global response to the HIV/AIDS epidemic, 2003'.In 2004, key elements of this material have been further updated by a study called *'Coverage of selected services for HIV/AIDS prevention and care in low- and middle-income countries in 2003'* (Policy Project, 2004). These two reports present progress on key global and national indicators in areas such as national response scale up, resources, eliminating stigma and discrimination, and prevention and treatment programmes.

Some of the key findings include the following: since 2002 global funding available to respond to AIDS almost tripled, but remains seriously inadequate, and—due to various blockages—is not reaching those who need it most; 38% of countries still have not adopted AIDS-related anti-discrimination legislation; and nearly one-third of countries lack policies that ensure women's equal access to critical prevention and care services.

The changing nature of the epidemic requires prevention efforts to be constantly renewed. For example, it has become clear that the overwhelming emphasis on more effective treatment in high-income countries since the latter half of the 1990s was to the detriment of renewed prevention efforts. Prevention gains stalled and, in many cases, rises in HIV transmission were experienced for the first time in a decade. Similarly, in Thailand, outstanding success in reducing transmission associated with

sex work in the 1990s changed the shape of the epidemic; now, the area of greatest need is within marriages and regular relationships. Equally the disparity in accessing treatment among couples is a critical issue. In most cases a man may be having information about treatment needs and due to economic power he may have access while the female spouse has no clue. This disparity needs redress through community based treatment literacy where every individual is informed and empowered to ways of getting access to treatment.

An issue of particular concern, AIDS has killed one or both parents of an estimated 12 million children in sub-Saharan Africa. Yet less than half of the countries with the most acute crisis have national policies in place to provide essential support to children orphaned or made vulnerable by the epidemic. To limit the impact of AIDS on the social and economic life of communities and countries, it is a political imperative that orphaned and vulnerable children are cared for. If the treatment were availed to some of the parents, they would still be caring for their children and the orphan crisis would have perhaps been reduced. The opportunity cost of not investing in treatment may be greater than it is imagines when one compares the cost of ARVs to the quality of life as well as social/economic responsibilities. The cost-effectiveness of various interventions should no be evaluated using medical indicators only, but should be comprehensive enough to capture social and welfare indicators.

Efforts to track resources and to prove they are being used efficiently also need strengthening, since this evidence is key to continuing financial support for programmes.

In addition to mobilizing still more funds, a great deal of work is needed to seriously scale up country programming capacity, and to clear blockages and bottlenecks in the system to ensure the money gets to where it is needed to support activities. AIDS itself has seriously depleted response capacity, and in many cases its impact has been worst in those communities and nations where capacity was already weakest as a result of decades of inadequate development. Bold new approaches are required to reinvest in human and community resources, starting with preserving lives to the greatest extent possible, including through the roll-out of antiretroviral therapy. Long- and short-term strategies are needed in equal measure. In the immediate term, most

countries possess untapped human capacity reserves in trained workforces that have retired or moved away from their professions. These resources are within communities in different setting such as rural and urban, informal and formal as well as in private and public sectors.

At the national level, all stakeholders need to accept that an effective AIDS response can only be achieved if countries own and drive it within their own borders. International assistance is important, but it only works effectively if it is embedded within a national response. The concepts of community as well as national ownership which is derived from participatory processes and methodologies whose underpinning guiding principles are multisectoral/multidisciplinary, multifaceted, mainstreaming, harmonization and coherence is needed.

This provides a basis for coordinating the work of all partners and stakeholders at country-level employing an appropriate monitoring and evaluation system. HIV/AIDS has several challenges, which cannot only be evaluated using scientific methods. The sensitivities and unique characteristics of not only being medical, but affects social, economic, psychological, spiritual and highly stigmatised makes it difficult to do traditional scientific evaluation. It would be desirable to employ methodologies such as case studies, role-play, personal testimonies as well as qualitative and quantitative data with attributes that reflect knowledge, attitudes, behaviour and practices.

2.1.2 AIDS as a social problem

The social construction of AIDS has enhanced particular attitudes towards the infected hence challenging the principle of individual freedom, responsibility and collective solidarity (Herzlich & Pierret 1989) as well as Nzioka 1994. From the 1980s, AIDS has been conceptualized as a moral panic (Weeks, 1989) and amplified and blown out of proportions by the mass media.

It has emerged that problems in managing HIV and AIDS patients who are stigmatized by society due to the conceptualization of the Disease as an ailment associated with sexual activities of particular groups such as prostitutes, the gay community and intravenous drug user are on the increase. Furthermore, among the

religious sector AIDS has been viewed as Gods retribution for Mans evils when experienced on a large scale, or as a punishment to the individual for immorality (Sontag 1989). This is evident in most religious teachings through the doctrine of purity and holiness (Jeremiah 19:2) and Deuteronomy 28:1-24 – used by some religious leaders to teach about AIDS. This kind of teaching is contrary to the life of Jesus Christ as portrayed in biblical teachings on Love and compassion for neighbour. This thought process is however slowly being replaced by more progressive thinking as 'AIDS is not a punishment from God' as well as the statements on stigma 'stigma is sin' or the 'the body of Christ has AIDS' all highlighted in the Anglican statements on HIV/AIDS in 2001 and 2003.

People with HIV/AIDS may require periods of hospital-based care, which render them a liability to both their families and the state. The demands of AIDS patients thus exert pressure on already overstretched family and government budgets (Onyango and Walji, 1988) and consume resources, which could otherwise have been expended on curable disease. The strain imposed on public health facilities by people with HIV/AIDS is already visible in the west. In Britain and Sweden, for example, even at a low estimate, the number of hospitals beds required for people with HIV/AIDS was projected to increase three or four fold in these two countries between 1989 and 1991 (Silverman, 1990).

In the absence of a cure for AIDS the most effective means of controlling the spread and HIV/AIDS lies in undermining its main mode of transmission. AIDS is not contagious but "simply a blood disease" (body fluid disease), which can be controlled with relatively simple precautions (Watney, 1988:54). Large - scale change in heterosexual practices can be difficult to achieve even when the population is well informed and other risk factors are evident. Sexuality is part of people's culture and may be difficult to change (Plummer, 2988:43). This implies that information and rhetoric's alone cannot bring about change in a given community unless the approach used is wholistic in nature with well-grounded supportive mechanisms and interventions.

2.1.3 Challenges faced by the Church in Africa

Twenty years from the on set of the AIDS epidemic, it is now argued that Faith Based Organizations (FBO's) and churches are better placed to deal with the AIDS crisis, due to the number of people they attract in their congregations who offer alms and offerings for church activities. However, a number of problems hinder the church from fully utilizing its strategic position for an effective and maximum impact in the fight against HIV and AIDS as well as the effects that the scourge has on communities and families.

One outstanding effect of HIV/AIDS in sub Saharan Africa and Kenya in particular is the growing number of orphans as a result of one or both parents dying from HIV/AIDS related deaths. What follows below are some of the challenges that the Anglican Church in Kenya and church's in Sub Saharan Africa are faced with as they grapple on how to prevent further infections and providing the needed care and support to people living with and personally affected by HIV/AIDS.

2.1.3.1 Care and support for orphans and families affected by AIDS

According to Saoke et al (1996) many countries in Sub Saharan Africa are under siege by an orphan crisis that will not be adequately addressed by the construction of more orphanages. The numbers are too high and the need for care is too great. It is important to note that the overwhelming majority, certainly over 90 percent of the children orphaned by AIDS in the most affected countries, live within their extended family and community; a fundamental response must be to strengthen the capacities of families and communities to protect and care for their children.

> *This disease has affected us very much, half of my congregation are orphans and widows, I have 200 orphans and vulnerable children and 50 widows in this church. All these people need help, where do I get it? A pastor, Homa bay district. – UNICEF 2002*

The pastor in the above scenario brings to the fore the challenge of orphans and vulnerable children that the Church and other religious institutions requires to intervene. The sense of helplessness in his remarks is echoed in the media as well as pulpits across Kenya in the Anglican Church and other denominations. This calls for strategies to enable pastors and members of the Church to tackle the increasing need for caring for the children who are left behind as a result one or both of their parents dying from AIDS related ailments. The 2002 UNAIDS report indicates that an estimated 14 million children who have lost either one parent or both due to AIDS are living across the globe. Out of this figure approximately 80% i.e. 11 million are in sub Saharan Africa. Kenya, the country under study has over 890,000 orphans and the numbers are expected to rise in ten to twenty years since the infection prevalence rates have not reduced. However the Most Rev Njongonkulu Ndugane- Archbishop of the Anglican Church of Southern Africa, in January 2003 expressed that;

> *...It has broken my heart and those in many nations who realize that too many children, whose parents have died from AIDS, have themselves been treated like diseased pariah. Children have been rejected, isolated, alienated and ignored. Their childhoods, the time of developing values and learning life skills, have been curtailed or distorted simply because a parent was infected. There are ghastly reports of children being starved in their home communities and treated as outcasts. This is a sin. For in the shadows of hatred and fear we find the fertile soil for planting seeds of the next of this pandemic.*

For many orphans the process of finding a home or guardian can be made more difficult by aspects of gender, social class, HIV status and myths surrounding the death of one or both parents of the child. These barriers still permeate much of the continent including the country under study and the selected study site of the Diocese of All Saints under the jurisdictions of the Anglican church of Kenya. Yet Kenyan social researchers are only beginning to make a significant contribution to this area of scholarship.

According to literature findings, the annual number of new infections has remained steady, but it hides dynamic trends. In some Sub Saharan countries, the epidemic is still growing despite its severity. Others face a growing danger of explosive growth.

Approximately 3.5 million new infections occurred in the region in 2002 UNAIDS (2002).

The risk of HIV spread often increases when desperation takes hold and communities are wretched apart. At the same time, the ability to stall the epidemics growth also suffers, as does the capacity to provide adequate treatment, care and support. The challenge for the Anglican church is to being central to networks of community support, to meet the health care and basic needs of those who are orphaned, ill or excluded due to HIV, freeing them to productive life as long as their health permits.

Since the numbers of orphans and AIDS patients is growing and expected to grow, the implication here is that the needs are expanding beyond what the extended family can provide. Growing needs such as food, clothing, medicines (ARV's), shelter, education cannot be sufficiently provided by the new 'breed of parents' the grandparents and other immediate relations who have financial and economic implications in additional members to their household on the over stretched resources. These therefore call for an external support safety net before the children whose parents have died are totally abandoned, neglected, abused and the pressure mounts on the state run institutions.

2.1.3.2 Counseling of people living with and personnaly affected by HIV/AIDS

People living with HIV/AIDS experience a variety of social support needs, psychological distress and spiritual yearning. The HIV positive person may experience income reduction or unemployment as a result of severe illness.

Counseling services for the HIV is an integral part of the management process of the illness (Harris 1990). Counseling services enables infected and affected people to adjust in line with the health situation. For along time counseling has not received much attention from the government. The counseling services offered are only during the testing period and very little follow up. Besides the clinical counseling provided at testing centers, there is need for spiritual counseling that may enhance hope in people who have tested positive or those who are negative to enable them

choose alternative ways of life for example abstinence. In most hospital counseling cases, spiritual counseling has not been given adequate attention.

The number of medical personnel trained in counseling, let alone HIV/AIDS counseling, is quite low in Kenyan health institutions. According to Nzioka (1994) the government does not have a training programme for counselling so it relies heavily on training offered by NGOS Such as AMREF, Red Cross and Churches.

The ministry of health guidelines on HIV/AIDS counselling states that the diagnosing clinical officer has to provide counselling and psychological support to the patient with positive blood test or presumptive clinical diagnosis. But the number of trained health officials in counselling is small as compared to the national demand. This shortage in manpower and the subsequent ineffectiveness in counselling services is acknowledged by the MOH.

The inappropriate health worker-patient ratio resulting in short contact periods between counsellors and patients has reduced the frequency and effectiveness in most centres. The church therefore has a challenge to promote voluntary counselling and testing for HIV as a ministry of the Church as well as the establishment of support groups and other counselling services for those who are orphaned, ill, afraid, dying or bereaved.

2.1.3.3 Church Leadership

In any organization, leadership is very crucial as it helps pave the way for members to react to situations of distress or conflict and also provides guidelines for the operations of the organization as it carries out its activities. In the face of HIV/AIDS, there are a number of factors which hinder church leaders like pastors/priests; bishops; group leaders like youth leaders; mother's union and men's Anglican fellowship leaders and church council and committee leaders to strategies on interventions to fight against the further spread of HIV/AIDS and its effects on members.

The church leaders, especially the Bishops and the clergy are accorded high respect in their communities and are usually believed without much question. The church also has other networks, which include schools, colleges, hospitals and health center, which are used to deliver related services. All in all, the church is involved in people's everyday living, they prepare young men and women for marriage, they baptize people's children, they visit the sick and the bereaved, they bury the dead and hence the church leadership is with the people all the time. However, the church is faced with challenges as it encounters people living with and personally affected by HIV/AIDS in the above mentioned, the challenges include silence, stigma and discrimination, power struggle, despair, knowledge on the modes of transmission of HIV, issues of sex and sexuality.

Silence permits inaction and is the breeding ground for stigma, Judge and Schaay (2001:7). Church leadership has to be bold and compassionate to prevent infection and care for all the ill and dying. By so doing, the Church leadership will serve as a model for leadership in government, and all civil society.

Issues of power, culture and morality are some of the challenges of the Church leadership today. Leaders have to advocate for affordable Anti retro viral drugs (ARV's). HIV calls for bold and creative approaches by leaders, which recognizes the reality of power and gender patterns at all community levels, and mobilizes resources and facilitate development of new models of leadership, particularly among laity and women. However, there is no clear policy to guide church and state partnerships in the fight against HIV/AIDS. This lack of collective responsibility is one of the hindrances in developing long-term strategies on treatment and availability of essential drugs for HIV patients.

Helpless resignation refers to the attitude of leaders and Christians who wish to respond, but have given up in despair due to an apparent lack of skills, knowledge, resources and courage Okaleet (2001). While the media and other communication initiatives (in Kenya) are doing a lot to empower people, a comprehensive and deliberate programme to empower the church and its leaders is however imperative.

WCC (1997:2) holds that, the very relevance of the churches will be determined by their response to the pandemic. The crisis also challenges the churches to re – examine the human conditions, which in fact promote the pandemic, and to sharpen their awareness of people's humanity to one another, of broken relationships and unjust structures, and their own complacency and complicity. HIV and AIDS is a sign of times, calling the Church to see and understand. With the persistent silence, human sexuality debates that focus on ideologies and theological differences, church wrangles, despair, lack of policies to guide members, AIDS will continue to be a leading cause of death in Sub Saharan Africa. This calls for a deeper reflection on interventions rather than focusing on what divides the church i.e. ideological differences.

2.1.3.4 Theological reflections in line with HIV and AIDS

Some of the theological questions that arise as a result of HIV and AIDS within the churches have been highlighted in religious literature. "Why does God allow the HIV virus to exist?" or "what is God doing about the epidemic?" or "What beliefs about God and human beings should inspire the churches' actions in response to HIV/AIDS?" WCC (1997:20). In exploring this challenge, a deeper reflection by theologians in the Anglican Church and other denominations has to be undertaken. This should be guided by church leadership in consultation with other professional bodies like medical doctors – epidemiologists, sociologists and economists. This is one of the pertinent challenges the Church in Africa is faced with. It is the task of the church to gather for study, for prayer and for worship.

The churches' challenge is to constantly engage in theological reflection, seeking discernment on the issues of sexuality, sin, guilt, grace, judgment and forgiveness. The church is called to action in times of need, but how well equipped is the ACK to face the challenges that come with the AIDS scourge? What policies are in place in line with HIV and AIDS?

2.1.3.5 Stigma Hampers Prevention

AIDS-related stigma and discrimination directly hamper the effectiveness of AIDS responses. Stigma and concerns about discrimination constitute a major barrier to people coming forward to have an HIV test, and directly affect the likelihood of protective behaviours. For example, the silence around HIV can prevent the use of condoms or can lead to HIV-positive women breastfeeding their infants for fear of being identified.

Stigma is not only directed towards people living with HIV. In many cases, HIV stigma has attached itself to pre-existing stigmas—to racial and ethnic stereotypes and to discrimination against women and sexual minorities. At the same time, long-standing patterns of racial, ethnic and sexual inequality increase vulnerability to HIV. In many countries stigma and discrimination remain important barriers to understanding how marginalised groups of society are coping with the epidemic. This gap has led to lack of interventions that are inclusive and therefore has left them out in many other areas including targeted information on life prolonging information including literacy on available treatment and coping mechanisms.

Data now show that relatively new epidemics in East Asia, Eastern Europe and Central Asia are spreading fast. Despite the overwhelming evidence that AIDS is everywhere, the impulse to say AIDS is only a problem 'somewhere else' is still strong. In such a climate, people who are stigmatized and live on the margins of society, such as injecting drug users and men who have sex with men, are often badly served by prevention programmes. In some countries, their care and support needs are systematically ignored.

Brown (et al 2001) as cited in Dejong, 2003, divided stigma into felt or perceived stigma and enacted stigma. Felt stigma refers to real or imaged fear of societal attitudes and potential discrimination arising from a particular undesirable attribute or diseases or association with a particular group. Stigma associated with HIV/AIDS continues to profoundly affect HIV prevention efforts, leading people to deny risk, avoiding testing, delaying treatment and suffer needlessly. Stigma occurs at the structural level, in the form of leadership and regulations, as well as more explicitly at

community and individual levels. Homophobia continues to hamper HIV prevention efforts at all levels.

In a statement of the CAPA HIV/AIDS board, the members state:

> *Stigma is the silent killer decimating our continent and is spreading disease. We call for an end to stigma and discrimination against those who are HIV + and their families. Our sisters and brothers living with AIDS experience silence and rejection. Silence feeds denial and shame. This, too, is stigma. We know the Church has been complicit in silence. That silence is ended! Our Church has declared stigma as a sin before God and Human kind. We will uphold the dignity and worth of all people as Children of God, especially those living with AIDS. Therefore each Province is being asked to implement a Pastoral Plan for eradicating stigma as soon a possible. (CAPA; August 2002).*

The CAPA statement implies that the Anglican Church has declared war against the AIDS scourge and the stigma attached to it. It also notes the presence of stigma, denial and discrimination of HIV positive people in the church and by the church especially church leadership who continue to be silent regarding the disease and its implications. The statement also indicates that God does not hate sinners but hates sin, therefore, the church as a true representation of Christ's compassion and love ought to be welcoming to people regardless of their HIV status.

The church has recognized that stigma is wrong, but the eradication of stigma is still far from reality. It is now evident that the Anglican Church has moved away from rhetoric's to action as indicated by the growing number of countries (Provinces) developing HIV/AIDS policies and drawing policies in line with stigma eradication as is the case for Uganda, Tanzania, Nigeria and Southern Africa.

2.1.4 The All Africa Anglican AIDS Initiative as an interventional strategy

It is in recognition of the threat posed by HIV/AIDS that Anglican Churches in Africa have committed their own and their development partners' resources to respond to the

crisis, Aluku (2002:5-6). The All Africa Anglican initiative to eradicate HIV/AIDS in sub Saharan Africa was the vision of the Archbishop of Canterbury and the Primates of the Anglican Communion when they met at Kanuga Conference Center, USA, in March 2001.

As a result of the action plan of the Primates, the Archbishop of Cape Town was mandated to coordinate a workshop for the Provinces of Africa. The Council of Anglican Provinces of Africa (CAPA) Archbishops supported the workshop by sending representatives from each one of the Provinces and the CAPA General Secretary to the All Africa Anglican Conference on HIV/AIDS, held in Boksburg, Gauteng South Africa, 13 -16 August 2001.

The Council of Anglican Provinces of Africa (CAPA) is the coordinating structure of the Anglican Church in Africa, comprising the 12 Anglican Provinces of Africa plus the Diocese of Egypt and representing the leadership of 42 million Anglicans on the Continent. The Anglican Church in Africa thus stands firm and pledges that "future generations will be born and live in a world free from AIDS" (All Africa Anglican Planning frame of 2001). This is evident in the establishment of HIV/AIDS desks across the CAPA provinces including Kenya. In Kenya, the house of bishop's in 2003 approved the establishment of HIV/AIDS desks in the 29 dioceses across the country. This has already been effected in all the diocese.

The CAPA HIV vision implies that the Anglican Church has gone beyond talk to implementation through the development of strategic plans to enable the church have a clear strategy in its HIV/AIDS interventions. The leaders of the Anglican Church have given specific attention to Prevention, pastoral care, counselling, HIV care, death and dying and leadership (see Fig. 1 on page 50). The statement however assumes that all the Provinces of the Anglican Church have implemented activities at all levels. It further assumes that the church has laid down strategies of dealing with the HIV/AIDS in all sectors of the church structure.

As AIDS continued to ravage Africa, the Anglican Church worldwide, felt it important to start up an AIDS planning framework to guide all Anglicans in Africa and beyond. This would enable the church leadership i.e. bishops and archbishops

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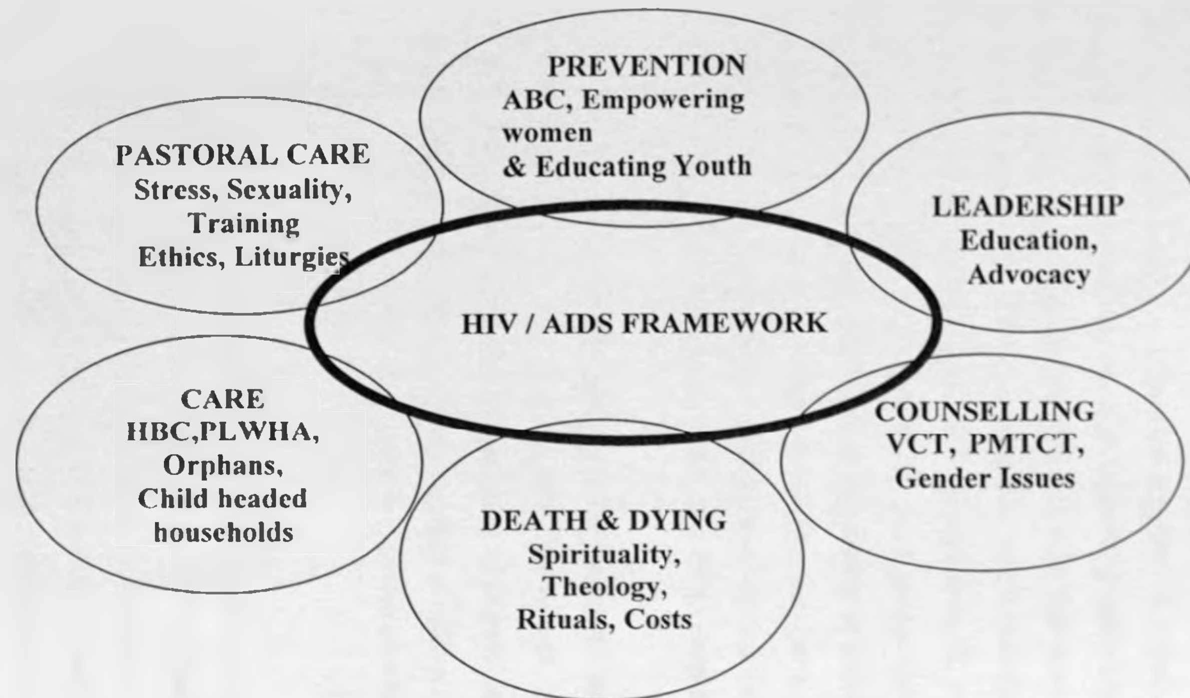
draw their members together in a participatory manner to reflect on the challenges posssed by HIV/AIDS. The planning framework would enable provinces (Anglican national coordinating bodies) bring all key stake holders to assess, plan, design, implement, monitor and evaluate their own projects/interventions. CAPA was mandated with the responsibility of coordinating and making sure that the programmes are implemented by the member churches.

Fig. 1. The All Africa Anglican Planning framework



Source: Aluku 2003 in a CAPA presentation at ICASA

The above diagram illustrates the All Africa Anglican Planning framework, which is expected to guide all Anglicans in setting up HIV/AIDS interventions at both national and diocesan level. The framework has six components, which are discussed in detail below;

Prevention entails speaking openly and with moral authority about responsible sexual behavior. Pastoral care entails equipping clergy and laity to support all people, especially people living with HIV/AIDS. Counseling involves supporting voluntary counseling and testing, and establishing support groups for those who are orphaned, ill, afraid, dying, and bereaved. Care entails serving as the foundation of community networks to meet the health care and basic needs of those who are orphaned, ill, or excluded. Death and dying involves transforming the practices by which people care for those who are ill so that they never suffer alone and marking the passing of those who die so as to preserve scarce resources and protect those who survive. Leadership in the framework entails seeking bold, compassionate community and institutional leadership to mobilize resources, particularly access to basic health care for all people.

These are the building blocks of the Anglican Church in Africa, the different parts can function independently hence a congregation or diocese can identify one part of the framework to concentrate on or as a point of entry into the initiative. However, an effective intervention in one part of the framework can affect the whole structure in other parts of the country (different diocese) are undertaking part or the whole of the framework.

Guided by the vision articulated in the words; "In our vision and God's call to transform, we confess our sins of judgment, ignorance, silence, indifference and denial, we commit ourselves to the promise that future generations will be born and live in a world free from AIDS", the Anglican church is now committed towards changing its view on HIV/AIDS. It can however be argued that the Anglican Church is good in talking and very little practical action on the ground. It is however evident through the first Province to use the planning framework that there can be a great shift from rhetoric's to tangible projects and actions on the ground.

Working together, CAPA and the Provinces of the Anglican Churches are demonstrating how the Church in partnership with donors, local and national

authorities, and other faith groups, can develop and deliver on-the-ground assistance to those who are ill and to their communities. As Stephen Lewis points out, the Church in Africa reaches into every community. The Church has undertaken to acquire the special skills required for the HIV/AIDS ministry; assembled groups of volunteer workers and advocates; motivated by the intention to care for those who cannot care for themselves; called to reject stigma; offered an infrastructure that, properly employed, can avoid the fragmentation and duplication that can result from multiple individual relationships among isolated recipients, donors and offered a venue if funded properly can be the basis for a much larger and broader response to the HIV/AIDS crisis. (CAPA/CORE proceedings, September 2003).

The Anglican Church in southern Africa is proof to this in that it has an establish strategic plan and is implementing the six areas of the framework. Its HIV/AIDS ministry is to date the most highly funded Anglican programme, which has set goals and viable objectives. The church is meeting its set indicators and the needs of the community it is serving. However, this may not be the case for all the member churches, which have adopted the framework hence the need for this study.

The Anglican Communion is not only committing itself to the prevention and spread of HIV/AIDS, but also embracing fully the view that all life is sacred. Ultimately the churches are called upon to place hope where people living with HIV/AIDS can experience care, comfort and support. Among the various positions the church has taken in regard to HIV/AIDS include the beliefs that:

1) The church has a moral responsibility to provide accurate information and education,

2) Allowing individuals and couples to make an informed choice about testing and the future of their relationships.

3) The church has a solemn duty to speak to the world on the HIV/AIDS crisis.

However, the challenge that faces the Anglican Church is to take up some concrete action beyond beliefs and promises in order to be viewed as a serious partner in the

fight against HIV/AIDS. There needs to be people level impact at the grassroots level and tangible documentation in terms of best practices or good examples on interventions like post positive test clubs; community orphan care projects etc. This calls for skilled staff at all levels to design and implement programmes as envisaged by the members. The 2002 UNAIDS report, Accelerating Action Against AIDS in Africa, points strongly to the "need to scale up," asks governments and others to "integrate the HIV/AIDS response into broader development and humanitarian initiatives," calls for "a sharp rise in international spending," and declares that "donors must also support the establishment of systems, incentives, and mechanisms needed to manage a robust AIDS response."

2.1.5 The ACK HIV/AIDS Initiative

In the ACK's vision and mission statement there is a stress on the ability to equip all God's people i.e. communities to respond to challenges of the new millennium. The challenges of the millennium include HIV/AIDS. However, a vision or mission without tangible action is not viable in dealing with the AIDS scourge. To this effect, the Anglican Church of Kenya through a twin structural arrangement combining direct approaches to dioceses and also to the community members through the (CCS) regional structure has resulted in impact at congregation and the wider interfaith communities.

The church has been seeking to serve the needs of people infected and affected by HIV/AIDS since the beginning of the pandemic. In June 1999 ACK bishops and staff met in Kanamai to examine the gap in the Church's response to HIV/AIDS and came up with a policy on Reproductive Health and HIV/AIDS. Within the policy, the bishops commit themselves to respond with speed to issues relating to youth and gender, reproductive health, behavior change as a strategy in combating HIV/AIDS and collaboration and networking in the fight against HIV/AIDS. (ACK documentation).

To that effect, ACK has developed pioneering innovative approaches such as home based care, both for people living with HIV/AIDS and for affected children. It also

provides a significant proportion of health and educational services. The church has an infrastructure network from the national level to the grassroots and this infrastructure has got personnel at all levels that are resourceful in the fight against HIV/AIDS.

One of ACK's goals is to address the needs of the poor using strategies that are holistic and that lead to measurable results at the family and community level. This could help in working for the improvement in the quality of life for Kenyans with a view to attaining household (family) sufficiency. This is realistic in that, the church is present in communities all over the country. It has deep historical roots and is closely linked to the cultural and social environment of the people and has effective channels of communication that can be utilized. The main purpose of the ACK AIDS programme is to empower community members and in particular church workers, clergy and leaders with abilities, information, skills and knowledge in order to effectively address issues related to HIV/AIDS at all levels of our society.

To reduce the high prevalence and spread of HIV/AIDS the church has embarked on a sensitization campaign towards the reduction of HIV/AIDS. Through effective education, counseling, and advocacy, the church targets these prevention strategies to reach the youth, orphans, single parents and widows/widowers. This is evidenced in the walk organised by the church leadership the Most Rev. Benjamin Nzimbi Archbishop of ACK in 2003 to create awareness among church members as well as communities at large.

Above all, the church has helped in promoting the re-establishment of a family and community support system that enhances coping, restores societal values of care and support for orphans and fights stigma, discrimination and denial. These have enhanced the church's leadership role in bringing hope in a wounded society and compassion for the infected and affected. This is evidenced through the established care institutions like St Nicholas children's home in Nairobi, the 63 health care centers across the country and the home and hospital visitations done by the mother's union – a care and support arm of the Anglican Church.

Other activities being conducted by the church include HIV/AIDS training on leadership, education, advocacy, home based care, counseling and care for the dying. Through the department of Theological education by extension, the Anglican Church has developed a week of studies on HIV/AIDS, 'facing AIDS: What hope can Christians give?'. The booklet contains five studies which the student should complete at home, doing one a day. The TEE group then meets for a discussion seminar to look together at how to apply what they have learnt in their individual lives and in the life of the Church and community to which they belong. (Facing AIDS 2003)

Another activity is the earlier alluded to awareness creation through HIV/AIDS walk organized by ACK and the Kenya ministry of health representatives. The walk was held on the streets of Nairobi to show Kenyans that the Church is committed to the fight against HIV/AIDS through and its support to the governments initiative of 'total war against AIDS'.

The church also has a programme called the Christian women of faith programme. This constitutes a group of about 250 former commercial sex workers. The people were drawn together in the beginning of 2003 and they meet once a week to pray and fellowship together.

The ACK has put in place a national coordinating office to address the HIV/AIDS issues in the church. The office is based in Nairobi under the Provincial (headquarters) office. The office has four trained staff in Public health, monitoring and Evaluation, theology and administration. In terms of structures, the programme

As the study was being undertaken, the ACK HIV/AIDS prgramme was in the process of conducting a needs assessment as part of the strategic plan documentation. This is a major activity of the Anglican Church, which is being done in phases so that they can come out with a comprehensive plan. A five-man committee was formed in 2003 to start the process of writing the plan. The process started with data collection, which is still continuing in other dioceses while nearly half of the ACK dioceses have completed. All the ACK Bishops meeting in Mombasa in August 2003, contributed

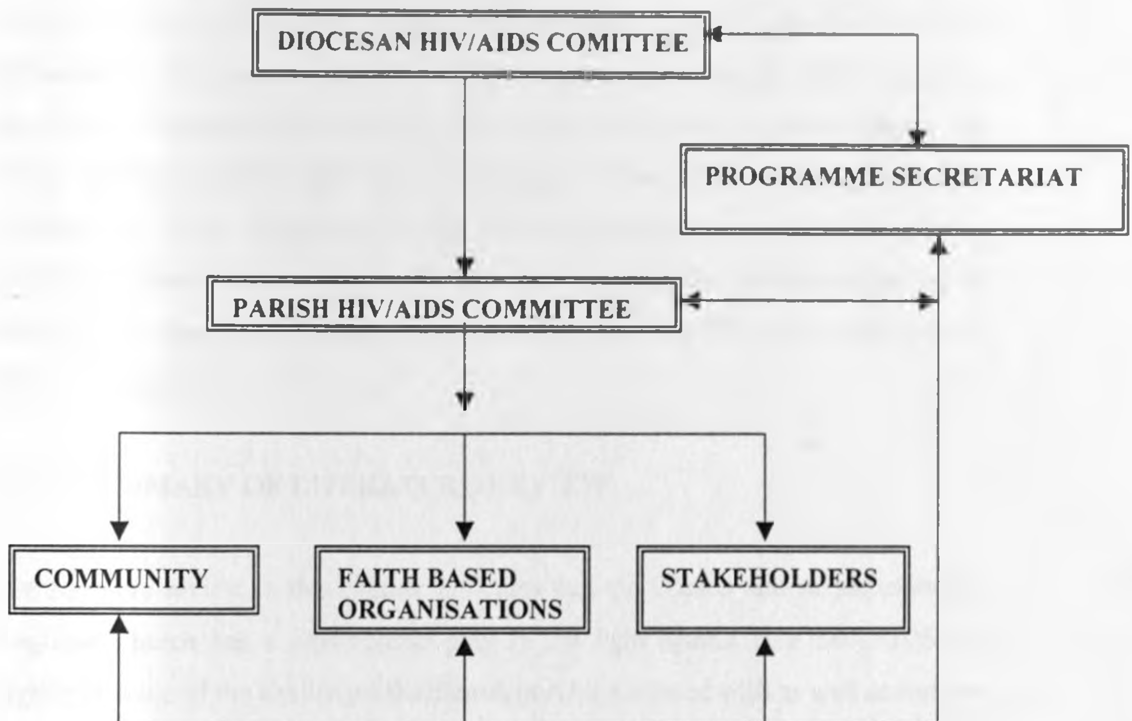
to the process, and gave their vision and strategy of implementation. This included setting up of Diocesan HIV/AIDS desks and employment of coordinators.

It should however be noted here that member churches (dioceses) under ACK have been conducting their own activities in their respective regions. The aim of the provincial office is to document the existing interventions and bring them together under one national strategic plan. An example of a fully operational HIV/AIDS intervention is the Inter-Diocesan Christian Community Services (IDCCS) ACK Diocese of Kisumu, Homa Bay and South Nyanza. This non for profit development unit of the Anglican Dioceses in the Nyanza province has been working with the disadvantaged communities in order to alleviate ill health and poverty. The organization therefore cover the area stretching along Lake Victoria down tot eh Tanzanian border, an area which has one of the highest HIV/AIDS prevalence in the country.

Through the use of participatory approaches to community mobilization and programme planning the development office is actively engaged in meeting the HIV/AIDS challenge. Their first priority is to reduce the spread of HIV/AIDS by increasing the positive attitudinal and behavioral change. 250 student leaders are being equipped with the relevant skills and tools to provide peer counseling on HIV/AIDS and other sexually transmitted diseases in three project sites. This is therefore an example of what some bodies of the ACK are doing as a response to challenges brought about by HIV/AIDS.

There is however a gap in the literature in terms of the interventions that the ACK has in the region of Nairobi especially under the All Saints diocese. The literature does not highlight specific interventions; strategies, policies and tangible activities carried out by the diocese of All Saints. The information available only describes what the diocese intends to do and not what it is doing. From the diocesan documents there exists a diocesan HIV/AIDS committee. Figure 2 below shows the proposed structure of the HIV/AIDS ministry;

Fig. 2. The proposed structure of the diocese of All Saints HIV/AIDS Ministry



The diocese in its documentation only states propositions to implement a project "HIV/AIDS prevention, care and Support, behavior change and distigmatisation through counseling, awareness creation, pasturing, home based care and mitigating against the economic impact targeting all the church members and their communities". (Diocese of All Saints Proposal 2004) The statement is a proposition of things to come and not what the diocese is currently undertaking.

The above organizational structure for example depicts the structure that will be established to run the project taking into consideration the existing structures i.e. Parish council, HIV/AIDS ministry. The Diocesan HIV/AIDS Committee will be in

charge of the programme while the Programme Secretariat will be responsible to the Diocesan HIV/AIDS Committee and in charge of the day-to-day operations of the project. The Parish HIV/AIDS Committee is to be directly in charge of the community, FBOs and stakeholders activities and will work closely with Secretariat in ensuring the timely implementation of the project activities.

There is a clear lack of policy on HIV/AIDS and reproductive health that can guide the church in its response to the HIV/AIDS pandemic apart from the policy regarding the 'Holy communion cup' which gives members the option of either dipping the "body" or drinking from the "communion cup". There is an on going debate on whether HIV can be transmitted through the shared communion cup. This is an area for further research and was not fully addressed by this study. These are some of the interventions noted in the literature in as far as the provincial HIV/AIDS and diocesan office is concerned.

2.1.6 SUMMARY OF LITERATURE REVIEW

The literature review in this chapter indicates that the Church and in particular the Anglican Church has a vital role to play in the fight against HIV and AIDS. It highlights some of the challenges the church in Africa is faced with as well as some of the interventional strategies employed by the Anglican Church.

The literature indicates that there are some activities being conducted the ACK but does not indicate whether there exist gaps in the interventions. Though the availability of funds and personnel is a vital element it is not the only independent variable that exists in the literature that can compound the effectiveness of the interventions.

Another factor that is highlighted in the literature is the vital role played by the religious leaders in the AIDS initiative. It is evident from the literature that the absence of leadership commitment in the fight against AIDS is detrimental to the whole Church initiative. Leadership therefore plays and important role in the HIV/AIDS planning framework.

2.2.0 THE THEORETICAL FRAMEWORK

A theory is a set of interrelated constructs (concepts) definitions and propositions that present a systematic view of a phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena (Kerlinger, 1964:11). Theory occupies an important place in research and research methods. Quite often, it is believed that a research without a theory is blind (Goode and Halt, 1952).

In the case of this study one theory related to the fight against HIV/AIDS is discussed. The overall aim is to seek for explanations on some aspects in the strategies used by the church against the disease. The study employed the situational approach theory in explaining the efforts mounted by the church towards HIV/AIDS reduction in the community.

2.2.1 SITUATIONAL APPROACH THEORY

The situational approach theory is a problem solving mechanism, which is relevant in explaining the approaches used by the church in the fight against HIV and AIDS. The situational approach theory as explained by Parsons (1951) seeks to explain human behaviour displayed in trying to correct an abnormal circumstance. This theory is based on situational behaviour that is seen as a response by an institution or a group of people who are struggling in various ways to eradicate a problem that is facing them. The situational approach theory has the following assumptions, which have relevance in this study.

First, it is assumed that human behaviour occurs when there is an experience affecting the definition of individuals and groups, their behaviour and influencing the situation and personality as well as changing the direction of situation. It is also, assumed that the efficiency in the definition of the HIV situation depends on other factors such as psychological, spiritual, information access, social influences and experience among others.

The approach is widely used in social sciences in explaining human behaviour. Thomas W.I. and Zanieck F (1974) used this theory in their studies and they have expounded it showing how humanity reacts to any social challenge. Parson (1951) viewed the situational approach theory as orientations while M. Weber (1947) explained theory from the point of giving a situation meaning.

Situational approach theory holds that human behaviour only occurs under certain conditions. There is nothing to define when people act as anticipated, but when confronted with a fatal problem to their lives, new stimuli demands attention from a group which is unprepared for an experience then the phenomenon assumes the aspect of a problem, disaster, crisis, where it is seen as a threat, a challenge, a call to new action (Volkart 1951). This is evidenced through the initial response of the Anglican Church, the overwhelming silence in preaching about HIV/AIDS during Sunday service and other Christian gatherings. The church it can be argued viewed HIV/AIDS as a threat brought about as a result of the sinful nature of the people and seen as God's punishment to sinners and outcasts. In this theory, a crisis is seen as the most significant of human experiences affecting the definition of individuals and group behaviours and finally influencing the situation and personality as well as the direction of change.

In this study, the theory seeks to explain the action taken by the church in its attempt to fight HIV. For the church tends to interpret the problem and adopt new mechanisms of therapeutic practice contingent to the illness situation affecting the community. Hence, this supports the central argument of situational approach theory that human behaviour is situationally determined.

A situation perceived by the affected person; depends on the early experience, intensity of the illness, fatality and other factors one expects to observe in the process of getting ill and the subsequent treatment. These factors singly or collectively determine the subsequent behaviour (Znaniecki, 1974). In a case of HIV/AIDS, perception of the situation prompts the church and others to seek alternative measures to fight the illness. The Churches' efforts are under stress because of the lives of their people who are experiencing the AIDS scourge. The issues of stigma come into play.

Seidel (1990) conceptualized AIDS as an illness perceived to be caused by witchcraft and or sorcery, that was Seidel's reaction to a situation of a condition with no much cure and considered as a disease brought about by an known powers. These perceptions and myths are also present in church members and have attracted responses such as seeking treatment from diviners and sorcerers. Too little or inappropriate information is disseminated, leaving African populations vulnerable to infection.

In responding to the situation of a disease with no cure has led to myths, such as having penetrative sex with a virgin will cure a person with HIV or AIDS, and misconceptions, especially about the modes of transmission of the HIV virus, such as using the same latrine or sharing utensils, for example, the holy communion cup, used by a person with HIV or AIDS can cause one to contract the virus. This has led to the development of policies in the Anglican Church on the Holy Communion cup. Where traditionally the Holy Communion cup is seen as a curative measure, the fear brought by HIV/AIDS as an illness/disease has led to this response by the church.

The definition of the illness situation for example, begins from the infected person, then relatives and the community where by it is internalized and becomes a social problem (Dreitzel, 1970, xi-xii). The initial definition of the situation is an element that confronts both the infected and affected people within their cultural norms.

There is a cultural rationale reflecting the normative traditions among the infected, the collectivity through the family, Church and the government. For example the Church is the one that is firmly rooted in the group with practical orientations to spiritual, psychological and social needs of those infected and affected. Therefore the Church is expected to observe its roles and respect the group beliefs, its responsibility and provide for the care of the community members. But due to the stigma attached to HIV/AIDS, the church has not performed her duties of care and support to the expectations of the community she serves. Stigma can be experienced at two levels

At this level, an individual, or a group develop a negative attitude towards another person, or other people whom they respond negatively towards. This type of stigma is known as societal stigma. It relates to societal attitudes and norms that stigmatize

people living with HIV. The individual often feels forced to do a 'self withdrawal' for fear of being judged, ostracized or shunned.

Where an individual practices self -denial discredits and underrates himself or herself. This type of stigma is known as self- stigma. Self-stigma begins with an individual not seeing the benefit of living and looking at himself/herself as unfortunate and contemplating what other people are going to think about him/her.

Stigma is caused by existing inequalities. Women, the youth, marginalized people such as drug users, racial and ethnic minorities are blamed for the transmission and spread of AIDS due to their position in society.

Pre-existing negative thoughts about certain groups or individuals is a major cause of stigma. For example there is a belief that those with HIV get it through their own bad behavior, namely sexual activity that is not socially sanctioned or goes against religious teachings. This leads to discrimination of people living with HIV/AIDS because the discriminating individuals or groups associate the infection with bad behavior.

Fear of contracting HIV/AIDS is another cause of stigma. Those who fear feel compelled to adopt extraordinary risk-averse behavior like not shaking hands, eating together or caring for people they know or suspect have been infected.

Ignorance or lack of knowledge of HIV is a big contributor to stigma. For example images of HIV/AIDS in the media which suggest that it is a woman's disease, black man's disease etc create HIV/AIDS related stigma by reinforcing stereotypes. The same is with some information from religious groups suggesting that HIV/AIDS is a disease of sinners.

Family members do view their relatives who have been infected by HIV as a disgrace. As people who have brought shame to the family by contracting the disease. As a result they develop a negative attitude towards their relatives who are infected. Some family members go to the extent of ostracizing their relatives who have been infected.

Health care institutions and health care workers sometimes perpetuate stigma by developing a negative attitude towards and discriminating against HIV/AIDS patients. There is the tendency by health care workers to view AIDS patients as "immoral" and "careless" in their sexual behavior. On the other hand, the media has contributed a great deal to stigma by sending flooding messages that associate AIDS with prostitution, drug addiction or homosexuality. Such messages if not well balanced with other ways of contracting the disease can lead to stigma. The messages create "infrequent" groups (the prostitutes, homosexuals and drug addicts) who are associated with an "infrequent" occurrence (AIDS).

At work places people who are known to be HIV positive are discriminated upon, some are sacked while others are retired simply because they tested or suspected to be HIV positive. The church has a strong religious obligation that ties it to the people hence the need to extend the health landscape to protect them in times of need especially by breaking the silence that surrounds stigma. The Anglican Church is using clergy who are HIV positive to speak out in church gatherings as a means to eradicating stigma and discrimination. The church shows family love and acceptance of the people living with HIV/AIDS by providing care and support, hopefully to avail the necessary comfort for the patient and the family.

We can however, argue that with forces of social change, most Churches like the Anglican Church are finding it difficult in coping with HIV/AIDS which is likely to hinder her ability to equally, attend other demanding spiritual issues. On the other hand, sociologically, the HIV/AIDS challenge is perceived differently. In this case social factors have a profound effect on both the experience and the occurrence of HIV/AIDS as well as upon how we react to people living with HIV/AIDS. Chances of contracting serious diseases such as HIV/AIDS are well influenced by social characteristics.

There are strongly defined social conventions about how family members are expected to behave when they have a patient. In this case caretakers may be exempted from normal duties to take care of the ailing person. This is the period when the

Church is concerned as the health provider, caretaker and lover. But it becomes so disturbing when AIDS illness becomes so serious beyond the family's level of care and health provision, hence the church reflecting deeper on issues of death and dying as earlier alluded in the literature review section.

Although the Churches' perception, interpretation and actions upon the HIV/AIDS illness are situationally determined and authentic, this has remarkable manipulation on its prevention and control. This therefore reveals that human beings are attempting to come to terms with situations in which they are victims. This theory is relevant and contributes to the understanding of studies on health seeking behaviour process in the reduction and control of HIV transmission. The Church responds to the pandemic in a slow manner due to the fear of losing its figure as a moral authority as well as due to lack of knowledge in dealing with the crisis that it is faced with.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

The research has used multiple methods of data collection relying on participatory research approach. The data collection includes qualitative and quantitative survey, with an emphasis on in-depth qualitative interviews. The qualitative component involved the use of focus groups, and open – ended interviews. The sample population was drawn from the parishes in the Diocese of All Saints. The site was selected based on proximity and empirical considerations as well as due to its complexity and multiplicity of situations i.e. affluent vs. less affluent, and its multi ethnic background.

The decision to use the participatory approach was based on the need to offset the limitations of standard approaches to data collection in cross – cultural setting, which included weaknesses in how measures are developed and once developed, whether they are meaningful. Measures developed without involvement of representatives of the subject groups may fall prey to poor validity exemplified by instruments that may be culturally insensitive, may use non relevant or difficult to understand categories and terms, and may not capture the reality of the subject's experience.

This chapter deals specifically with methodological aspects of the study. It outlines the areas where research was conducted, how data was collected, analyzed and presented. The study focused on the response of the Anglican Church in Kenya in fighting HIV/AIDS in All Saints Diocese in Nairobi. It should be noted here that the study was predominantly descriptive and aimed at documenting current work by ACK to access the work done in the HIV/AIDS initiative. The study was therefore not testing any hypothesis.

3.1 Selection of research site

This survey was conducted in the Anglican Diocese of All Saints which is found in Nairobi /Kajiado region. It is one of the four provinces, which form up the

Nairobi/Kajiado CCK region. The diocese comprises of 6 parishes with a total population of 10,000. The diocese is found within an urban set up and the majority of the followers of this church are Nairobi city dwellers. (ACK report 2003).

The parishes under the diocese are St Francis, Karen; St Luke's, Kenyatta; Holy Trinity, Kibera; St Joseph, Kabete; Christ the King, Ngando; and All Saints Cathedral, Kenyatta Avenue. The main practical reason that justified the selection of the study area is due to the increase in the prevalence rates of the virus in the region as well as the locality being the headquarters of the ACK. Nairobi has also been chosen because it is the Capital city of Kenya and has diverse ethnic groups, which comprises of people who are benefiting from the church programmes. This includes people who are infected and affected by HIV/AIDS in the area covered by the diocese of All Saints.

The area also covers the biggest slum area of Kibera, which is characterized by poor housing, sanitation and abject poverty. Many of the residents of Kibera are unemployed and many others are not in lucrative employment. These low-income areas are characterized by risky sexual behavior patterns like commercial sex, premarital un protected sex without considering safer sex – though no sexual act is 100% safe. Safer sex involves taking precautions that decrease the potential of transmitting or acquiring sexually transmitted infections (STIs), including HIV, while having sex. Using condoms correctly and consistently during sex is considered safer sex.

The diocese also covers the more up market areas like Karen, state house, Langata which are no exception because the well to do Kenyans have money to spend in bars, on soliciting sex and involvement in cross generational sex – sex with minors (PSI Kenya 2003).

3.2 Sources of data collection

For this study, both the primary and secondary sources of data were used. Primary data was obtained by interviewing members of the Anglican Church in the 6 parishes

of the All Saints Diocese, Pastors, Church leaders, mothers union, Kenya Anglican Men's Association and the staff at the ACK Headquarters. The two sources of data yielded a detailed and yet descriptive deduction about the units of analysis of the study.

Secondary data were collected through library research as well as HIV/AIDS information from written reports from the ACK HIV/AIDS office in Nairobi especially those possessing the number of members in the diocese and its affiliated parishes. Through the church reports we were able to access the different groupings for example the mothers union, Kenya Anglican Men's association as well as the kind of activities conducted by the different groups and committees.

A number of literature including Annual reports, project proposals, journals, books, newspapers, periodicals, government publications, research papers/reports and abstracts were reviewed. Secondary data have informed the study in terms of activities done in previous years, identification of groups and location of parishes. The data were considered vital because they pinpointed the nature and magnitude of the response of the Anglican Church in the fight against AIDS as well as identifying the priority areas for the Anglican Church. Desk research captured the other components of the study that were not captured by the primary data collection.

Primary data were collected in the field from members of the Anglican Diocese of All Saints, pastors and staff at the Provincial and diocesan HIV/AIDS programme desk. This was done by use of structured interviews, community meetings and by observation.

3.3.0 Study design

The study was descriptive in nature and therefore attempted to gain familiarity with the phenomenon under study through getting more information about people's views on HIV/AIDS. Since the study was predominantly descriptive, a cross sectional procedure was adopted to allow a standardized interview of the purposevilely selected respondents.

The research study design was. Predominantly qualitative but also had some aspects of quantitative research. The study design was very participatory in order to gain the confidence of the respondents as well as get more insight into the activities and barrier members faced in developing intervention. The study was also Illustrative rather than comprehensive due to the limitation of time and resources and also because it aimed at documenting the response by the church and an elucidation of factors promoting or inhibiting such responses.

3.4.0 Units of observation and units of analysis

This study interviewed parishioners at the All Saints Cathedral as earlier indicated as well as people benefiting directly from the HIV/AIDS programme initiated by the ACK in Nairobi. The beneficially included those in the church and outside the church. These were the people who participated as respondents in the process of data collection. The People Living with HIV or AIDS and their caregivers were selected as the observation units because they have the practical experience in the management of patients with HIV/AIDS. The other observation units were the Key informants.

Singleton (1998), defines the unit of analysis as the entity around which the researcher seeks to make generalizations. The unit of analysis of the study therefore was the efforts of the ACK church in reducing and controlling the spread of HIV/AIDS and acceptability of the initiative by its members. The unit of analysis was the initiative of the ACK under the diocese of All Saints in its fight against HIV/AIDS in the church. This included other components of the initiative such as the extent of acceptability of the initiative by members and non-members of the Anglican Church, factors influencing the acceptability, factors inhibiting the implementation of the initiative and the way forward for the AIDS initiative in the Anglican Church.

The study attempts to establish whether the Anglican Church of Kenya Diocese of All Saints HIV/AIDS initiative is effective and sustainable to be used as a model by other faith based organizations in Kenya. The units of analysis of the study focused on perceptions and explanations by respondents and focus group discussion participants.

3.5.0 Sampling design and procedures

In any scientific study, there is always a need to come up with an effective sampling design (frame) that can help select the respondents. Singleton (1988:137) observes that a sampling design refers to the part of the research plan that indicates how cases are to be selected for observation. Costs of the study can be limited through survey as asserted by Schutt (1996). Limited time and resources did not allow the researcher to interview all the members of the 6 All Saints Diocese parishes, hence the decision to purposively select groups and members from the parishes by requesting their coordinators, vicars and parish priests to identify people to represent the population of the church.

Non-probability methods were used in this study. In non-probability technique, by definition, non probability sample entails that the researcher relies on personal judgment to select units that are representative of the population by selecting respondents who are true representatives of the population in this case lay leaders in the church, those who have participated in church activities for the past three years and those who have joined the congregations in the past 9 months. The general strategy was to identify various sources of information and then select members that reflected these variations. This was done by the sending parishes and church groups.

Purposive selection of the respondents was used to select the expected churches in the diocese. This was done based on parish location and size. Furthermore, the parishes were selected based on records from the diocese indicating the initiatives on the ground and information from church members who fellowship in the different sectors. The study initially selected three parishes out of the 6. These were All Saints, Trinity Kibera and St Francis Karen. However, when the letters to the different groups were sent out, members of the Mother's union and Men's fellowship from the remaining 3 felt left out of the process and requested to have their views integrated in the study. This therefore led to the inclusion of all the 6 parishes.

Snowball procedures were used to select members from the different parishes. The method was used to identify respondents participating in one form or another in the ACK AIDS initiatives with a focus on the six call areas of the All Africa Anglican AIDS planning framework (refer to appendix 2), for instance, (HBC), awareness creation as a form of prevention strategy, orphan care, leadership training or those who had received advocacy training by the church, participated in a counseling course offered by the Church, participated in a diocesan or parish AIDS planning session, participated in a youth AIDS programme within the church set up, participated in the development of an AIDS liturgy. The study however only managed to reach 10 respondents in all the parishes using this method.

3.5.1 Sample size

The most important determinant of the study's sample size was heterogeneity of the target population. Singleton et al (1988:158) observes that the more heterogeneous the population with respect to the characteristics being studied, the more cases required to yield a reliable sample. Therefore, this study targeted members of the Anglican Church of Kenya according to the existing key groups of the Church namely Mother's union, (MU), Kenya Anglican Men's Association, (KAMA), Vicars, HIV/AIDS programme coordinators (staff) all drawn from the parishes under the All Saints Diocese. This was viewed by the researcher as realistic for the validity of the information required by the study, since the Diocese of All Saints has a population of 10,000 and ACK membership countrywide is currently 5 million and has the same structure (categories) of the mentioned groups across the country. All the respondents in the study were selected purposively.

The study area, All Saints diocese has 6 parishes. To select the respondents from the diocese, the researcher had a target of 5 respondents per group. From the 6 parishes the researcher hoped to get at least 16 respondents from each parish. It was felt that among the respondents we should have a representation of people who attend the parish to participate in the FGD's and interviews. In this case, the researcher had 4 categories of respondents in the 3 FGD's held during the study; Mother's union (MU), Kenya Anglican Men's fellowship (KAMA), Pastors/vicars and programme parish

staff. The respondents were chosen by their respective parishes through a letter submitted by the diocesan coordinators for mother's union and Kenya Anglican Men's Association (KAMA). Each of the six parishes was asked to send 5 representatives for each group i.e. 10 per parish. Other respondents were drawn using the snowball method. These included pastors/vicars and programme staff.

3.6.0 Techniques of Data collection

The study adopted 4 different data collection techniques, which are described here. They include; Key informant interviews, personal observations, community meetings, and review of documentary materials. The following methods were used in the study:

3.6.1 Structured Interviews

Personal interviews were conducted with vicars, priests and HIV/AIDS coordinators at the head office and at the parish/deanery level. Interviews also included ACK parishioners involved in HIV/AIDS activities; priests and church lay leaders both male and female. The interview schedule was a major tool in this study for guiding the respondents through set questions. This method was selected because it was found by the researcher in her work as advantageous because it gives room for checking any misunderstanding of a question, probing and also providing an opportunity for making observations since it is predominantly face-to-face. The aim of key informant interviews was to obtain information regarding the management of the ACK AIDS initiative, its set objectives, staff performance and other relevant information regarding the study at hand.

The interview schedule had both open and closed ended questions. The questions mainly revolve on areas considered as vital to the research such as personal views of the respondents regarding the ACK AIDS initiative, experiences at community level regarding the levels of acceptance of the initiative, and the overall rating of the initiative.

3.6.2 Personal observations

This is a method of collecting data from the respondents through participating in their activities and making facial observations of events as they unfold. The method entailed observing different behavior patterns of people as they happened in their set up for example how pastors behaved in the presence of people living with HIV/AIDS and affected communities as well as how people living with HIV/AIDS behaved in the presence of people who knew there HIV status visa-vie in the presence of people who did not know there status.

This meant that the researcher had to spend time with the different church groups in their settings. This was carried out simultaneously with other methods. The personal observations assisted in creating rapport between the researcher and respondents. Interaction with lay people, bishop's, clergy and ACK AIDS programme staff, resulted in personal experience sharing and observing the way community, parishioners and clergy perceive of the AIDS initiative. Personal observations also highlighted the cultural, gender, class and HIV myths and beliefs related to the initiative.

3.6.3 Community meetings

Community meetings such as; Congregation gatherings, Sunday school and youth meetings, mothers union meetings, HIV/AIDS parish committee meetings, seminars, workshops and conferences on HIV/AIDS were attended by the researcher. These meetings assisted the researcher to collect and collate data regarding the response of the Anglican Church in the fight against AIDS.

Through the meetings the researcher collected written and also heard verbal reports, views of members regarding HIV/AIDS and what the church ought to do or was doing in their locality. The method also enabled the researcher to note methodologies used by the church in conducting meetings and discussions.

3.6.4 Focus group discussions

Singleton et al (1988) defines a focus group, or group interview, as an exploratory research method used to help researchers gain a deeper understanding of their respondent's perceptions, feelings, motivations and desires. Focus groups are a well-respected means of gathering in-depth, qualitative information such as opinions and attitudes. Focus Groups bring six to twelve participants for an informal discussion lasting from one to two hours. The interviewees generally are of similar demographic or other predefined characteristics. The interviewer moderates the discussion based on an outline provided or approved by the respondents.

In this study three FGD's were held on different days and with groups of similar demographic characteristics namely the Mother's union (MU) a care and support arm of the Church; the Kenya Anglican Men's fellowship (KAMA) and an HIV/AIDS parish committee from one of the parishes. The researcher with the help of two research assistants arranged the meetings. When the groups assembled they went through a registration process, which included the programme for the 2-hour discussions; package on HIV/AIDS; stationery and logistics. The researcher then took the group through an introductory session and then the group discussions followed in break out sessions.

Using the FGD question guide, the questions were read out in the groups and anybody was free to respond to the question. The groups however had to set ground rules on how they would operate during the discussions. The researcher facilitated the discussions while encouraging the participants to talk freely. (Refer to appendix 1 for FGD questions)

3.5 METHODS OF DATA ANALYSIS

In analysing the data, descriptive statistical methods were employed. Descriptive statistical procedures were used to analyse and present the data. The study used descriptive statistics to analyse and present data, which contained respondents',

views, and opinions, expectations and other open-ended responses. These were done by using the frequency and simple averages. The data was presented in tables.

According to Singleton (1998), descriptive statistics are simple statistical methods concerned with organizations and summarizing of data to make it more intelligible. They categorize variables by summarizing patterns in the response of respondents and therefore reduce the huge mould of data into small meaningful quantities, which enables the researcher to identify the existing relationships and variations between dependent and independent variables of the study.

They include the measures of central tendency, percentages, frequencies, tables and pie charts, among others, The study used them because of the their simplicity and suitability in data analysis, presentation and comparisons. Conclusions and verifications were drawn. Data regularities, explanations, causal flows, and propositions were discussed. The generalizations have been made in relation to the theory discussed in the theoretical framework.

The study collected the views from the respondents and summarized them according to the set objectives of the study. All related data were analysed and the results summarized (refer to chapter 4). Conclusions were drawn based on the respondent's views.

3.5.1 Ethical considerations

Mugenda and Mugenda (1998) state that in the research profession, the researchers should abide by the professional ethics that govern the practice. To observe this guideline the researcher had to seek permission from the necessary authority before going out to the field for the interviews and focus group discussions. Since the researcher was interviewing people dealing with HIV/AIDS programmes, it was felt that any information regarding the privacy of the respondents should be handled with a lot of confidentiality so that it should not harm anybody involved. In this case the respondents' moral integrity was highly upheld.

CHAPTER FOUR

4.0 DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1.0 INTRODUCTION

This chapter provides an overview of the study findings through the use of descriptive statistics. The study results are discussed quantitatively using tables and direct quotations of the respondent's views.

The chapter is divided into various sections according to the set research questions and responses received under each category. Assessment of impact of the ACK HIV/AIDS Programme in the Diocese of All Saints is an initiative aimed at establishing the level of awareness of parishioners as far as HIV/AIDS is concerned and evaluating the level of effectiveness of programmes implemented.

4.1.1 Knowledge on the Provincial (National) and diocesan HIV/AIDS desks

According to the HIV/AIDS Provincial department, the ACK HIV/AIDS department is part of the holistic ministry objective of the church and aims at accomplishing the vision of the church through its set structures and policy of development. The department's vision is "a strengthened ACK leadership with the ability to eradicate HIV/AIDS and reverse the impact in the HIV/AIDS free society". Furthermore, the department has documented that its goal is, "to build the capacity of the Church with the right information to meet the challenges caused by HIV/AIDS in the community".

One of the strategies adopted by the department is the establishment of Diocesan HIV/AIDS desks. The programme received commitment from bishops to start HIV/AIDS programmes in all the 29 diocese and have desk coordinators. To this effect, all the 29 dioceses appointed desk coordinators in 2003. The aim of the desks

is to ensure that the coordinators train the 1215 priests in the parishes. It is envisaged that the 1215 priests will in turn train the evangelists and other church workers at the community level. The programme targets to reach the 5 million Anglicans over a period of three years.

From the study undertaken by this researcher, the HIV/AIDS desk both at the Provincial and Diocesan levels are not common knowledge to Parishioners as it was evident from the KAMA and MU that very few of the participants had heard about the desks and were yet to see them and learn of their activities. One of the participants remarked:

> *I know these desks are supposed to be existing and the Ministry of Health gave a land rover for HIV/AIDS activities not very long ago but I have never seen or heard of any activities on the ground*

While another commented that;

> *If the desks exist then whatever the activities being conducted must be centered around the headquarters (Provincial level).*

A few members learnt of the existence of these desks from members of the congregation, some heard of it through the synod and announcement at the Parish level. However the idea is remotely received. Participants from KAMA and MU cited insufficient communication from the Provincial/diocesan level to the parishes saying;

> *The aims, objectives and activities of these desks are unknown and therefore an effort should be made for such information to trickle down to the parishes either through announcements during church services or through seminars and workshops.*

From the discussions, the respondents stressed the need for a clear communication channel between the provincial office, the diocesan office and the parishes. To date, no clear channels exist to enable the flow of information regarding the activities and

interventions conducted or planned by the provincial/diocesan office. This indicates that unless there are some incentives members would not go out of their way to find out about the existence of the provincial or diocesan HIV/AIDS desks and what they entail.

4.2 HIV/AIDS programmes that have been initiated in the Parishes

In order to assess the capacity of the church in the diocese of all Saints in line with challenges the church faces as it implements or plans to put in place HIV/AIDS interventions in the designated study parishes, the researcher undertook to identify current programmes, activities and interventions in the diocese. What follows are the findings from selected parishes.

St Francis Karen

St. Francis parish has an HIV/AIDS committee in place, which draws representatives from the MU, KAMA, the youth and Sunday school teachers. The parishioners have been involved in various activities ranging from HBC of PLWHA's, advocacy, awareness creation amongst the members of the congregation and more especially among the youth in Primary and secondary schools both within and outside the parish and training of committee members.

St Francis as a parish has been able to minister and assist PLWHA's as far as Ngong Township. The member's offer counseling services to community members on a regular basis, 2 counselors are always available for this purpose. The counselors were trained by MAP international.

The parish solicits funds for its HIV/AIDS projects through proposal writing and participating in the AIDS council. The parish AIDS committee is registered with the Ministry of culture, Gender and sports as an organization working in HIV/AIDS issues. The parish networks with other CBO's involved in HIV/AIDS activities for example KANCO. They have also been conducting research on HIV/AIDS related issues in the slums within Karen/Langata area.

The MU meet every 1st Saturday of the month to pray, socialize and discuss issues about HIV/AIDS, while the men of St. Francis meet every 3 months to watch and listen to videos on HIV/AIDS.

According to the vicar of the parish who has been serving in that parish for 17 years, he has personally been involved in planning; developing and the implementation of HIV/AIDS related services or activities for one year. He further indicated during an interview that his parish has been involved in HIV/AIDS counseling, AIDS surveillance, AIDS orphan support, referral for HIV testing, technical support to AIDS organizations and bereavement support programmes for families. This reinforced the information gathered during the focus group discussion with the parish HIV/AIDS committee.

In terms of voluntary counseling and testing, the vicar commented;

> *We do not provide HIV testing but do counseling. We provide referrals to HIV testing clinics and sites. The counseling services are provided before and after testing. Our strategy is to reach to communities including villages to encourage people to get tested.*

The parish has endeavored to initiate activities at parish and community level, though the parish has well establish HIV/AIDS committee in place and is registered as a community based organization there is little impact on the ground in terms of people level impact in as far as meeting the needs of PLWHA's and people affected by the AIDS scourge are concerned i.e. provision of treatment, treatment preparedness, food, pastoral care, VCT, condom distribution, HIV education and prevention outreach as well as the ensuring sustainability of economic empowerment of people living with and personally affected by HIV/AIDS through employment services for persons with HIV/AIDS. These are the major gaps identified by this researcher at the parish.

The vicar of the parish said;

> *We need to develop vigorous programmes to involve the entire church. Collaboration to fight the pandemic must be emphasized regardless of ones religious affiliation or conviction.*

He therefore noted the gap in the Parishes' interventions and the lack of involvement of all members of the church in the fight against HIV/AIDS as well as the gap in as far as religious groups are concerned.

Holy Trinity Kibera

Holy Trinity Parish, Kibera, comprises of Kibera slums area, Makina and is located in the south west of Nairobi city. According to the vicar in charge, the Parish is involved in HIV/AIDS activities. The vicar in charge has been personally involved in planning and developing of HIV related services but has not been involved in the implementation of any HIV/AIDS activities.

The Parish offers HIV/AIDS counseling, outreach services, AIDS surveillance, diagnosis and treatment of tuberculosis and sexually transmitted infection this is done through their project Kibera Human Development started by the church and has also been running HIV/AIDS awareness and counseling programmes. The project is also making use of a clinic started by Africa Evangelistic Enterprise.

Other activities include referral for HIV testing clinics and sites, AIDS policy development, spiritual counseling and bereavement support programmes for families. The parish has been undertaking these activities for a period of 2 years. During a FGD a respondent from the parish pointed out that;

> *We would like to establish a well-facilitated programme on HIV/AIDS. However, we lack the financial resources to provide HIV education and prevention services.*

Though the parish has been providing some services including outreach to communities to encourage people to get tested for HIV and other sexually transmitted infections, the parish does not have full time staff devoted to the HIV/AIDS

interventions, no HIV/AIDS policies and strategy as well as a parish committee to address the needs and challenges brought about by the AIDS scourge.

The parish being located in the very low-income brackets of Nairobi where there are poor recreation facilities and other infrastructure has not made much impact in the community and the people it serves. The membership of the parish is estimated by the vicar in charge to be between 500-999. The vicar also estimated that the congregation has between 50-99 people living with HIV/AIDS. Out of which he estimates 25 adult males, 35 adult females, 15 adolescents and 15 children. To this effect the vicar in charge commented that;

> *It is my prayer that a cure for HIV/AIDS can be found, but we must address the pandemic by establishing support for PLWHA's and affected families as well as intensify prevention campaigns in our community.*

Even in the midst of hopelessness, there is hope among the church leadership that a solution can be found to help in the fight against HIV/AIDS. The absence of strategies and policies at the parish will however not enable them move a step forward.

All Saints Cathedral

A department Social Concern was set up to handle among inter alia HIV/AIDS support to PLWHA's, widows and orphans through visitations, giving gifts, training and counseling ministries. The Provost of the cathedral has given sermons with messages on HIV/AIDS;

> *We make use of the pulpit by preaching and teaching on issues related to HIV/AIDS. People Living With HIV/AIDS also given testimonies of their experiences.*

To date, all ministries in the church are allocated a certain amount of money for their activities by the PCC, HIV/AIDS inclusive. According to the mother's union;

Members usually identify a person living with HIV/AIDS and allocate an amount of money for example 1,000/- for commodities during visits. Needs assessments are done and PLWHA's are counseled accordingly.

The church has facilitated meetings for example, the observation of world international AIDS day (December 1st). The church uses the day to fellowship with PLWHA's by giving meals and money for transport. Such activities are open to all members and non-members of the All Saints parish. Some of the activities during the event include VCT services and general counseling.

The vicar commented that;

The All Saints cathedral being the national cathedral should develop an elaborate programme on HIV/AIDS because it is a center for learning to the entire ACK. Coupled with Christian love and compassion the programme will reach a wide community.

The parish is involved in HIV education and prevention, HIV/AIDS counseling, outreach services, AIDS surveillance, referral for HIV testing, spiritual counseling, bereavement support programme for families and use of bible/pulpit to influence behavior change.

The researcher however noted from the various interviews and FGD's that gaps exist in the parish in terms of technical support to AIDS organizations, AIDS policy development, food programmes for persons with HIV/AIDS, diagnosis and treatment of tuberculosis and sexually transmitted infections, AIDS orphan support services, medical treatment for HIV/AIDS and HIV testing services. There seems to be more talk than implementation, this however could be due to lack of resources as the Provost pointed out that;

We only deal with volunteers in our programme who may be limited. We may need permanent staff if resources would allow.

This also highlighted a gap in terms of the parishes capacity to take up responsibilities in the above-mentioned areas of intervention. Currently the parish does not have the capacity in terms of full time staff devoted to HIV/AIDS and can therefore not provide all the necessary programmes

Other parishes such as Christ the King Ngando situated along Ngong road, Ngandu area near Lenana school has not been involved in any forms of HIV/AIDS services planning, development and implementation. A pastor from the parish in one of the FGD's said;

> *We have not been providing any activities in the parish. The leadership in the parish has little or no knowledge on HIV testing and counseling. The parish lacks financial resources to provide direct HIV counseling and testing services leave alone treatment.*

This is one of the parishes that came out openly during the FGD discussions as well as during interviews that they did not have any form of HIV services or interventions on the ground. The leadership is however willing to work with other religious organizations in the country to fight the HIV/AIDS epidemic. The Archdeacon and vicar in charge however noted the important role that pastors have to play in the fight against HIV/AIDS;

> *Pastors are the people with the congregation/community and viable HIV/AIDS programmes within the parish are critically needed.*

St. Joseph Kabete is located in Uthiru village, West of Nairobi city. For the past three years according to the vicar in charge, the parish has been involved in HIV education and prevention through preaching, drama, videos and having PLWHA's to testify, HIV/AIDS counseling, referral for HIV testing, spiritual counseling, AIDS orphan support and bereavement support programme. One of the KAMA respondents pointed out that the parish does not provide HIV testing and counseling services due to;

The stigma associated with HIV/AIDS compounded with the reason that it is not part of our core programme to provide HIV testing and counseling services.

As noted in the literature review section, stigma continues to be a major hindrance in the fight against HIV/AIDS. The parish does not have any HIV/AIDS policies that would protect both people living with and personally affected by HIV/AIDS from stigmatisers in the community and within the church.

The other parishes namely St Augustine Madaraka, Kenya Science and Gatwikira have either only just formed an HIV/AIDS committee or are in the process of forming one. However, Gatwikira has a programme in place catering for PLWHA's, they run a clinic, which serves HIV/AIDS patients and also distributes food.

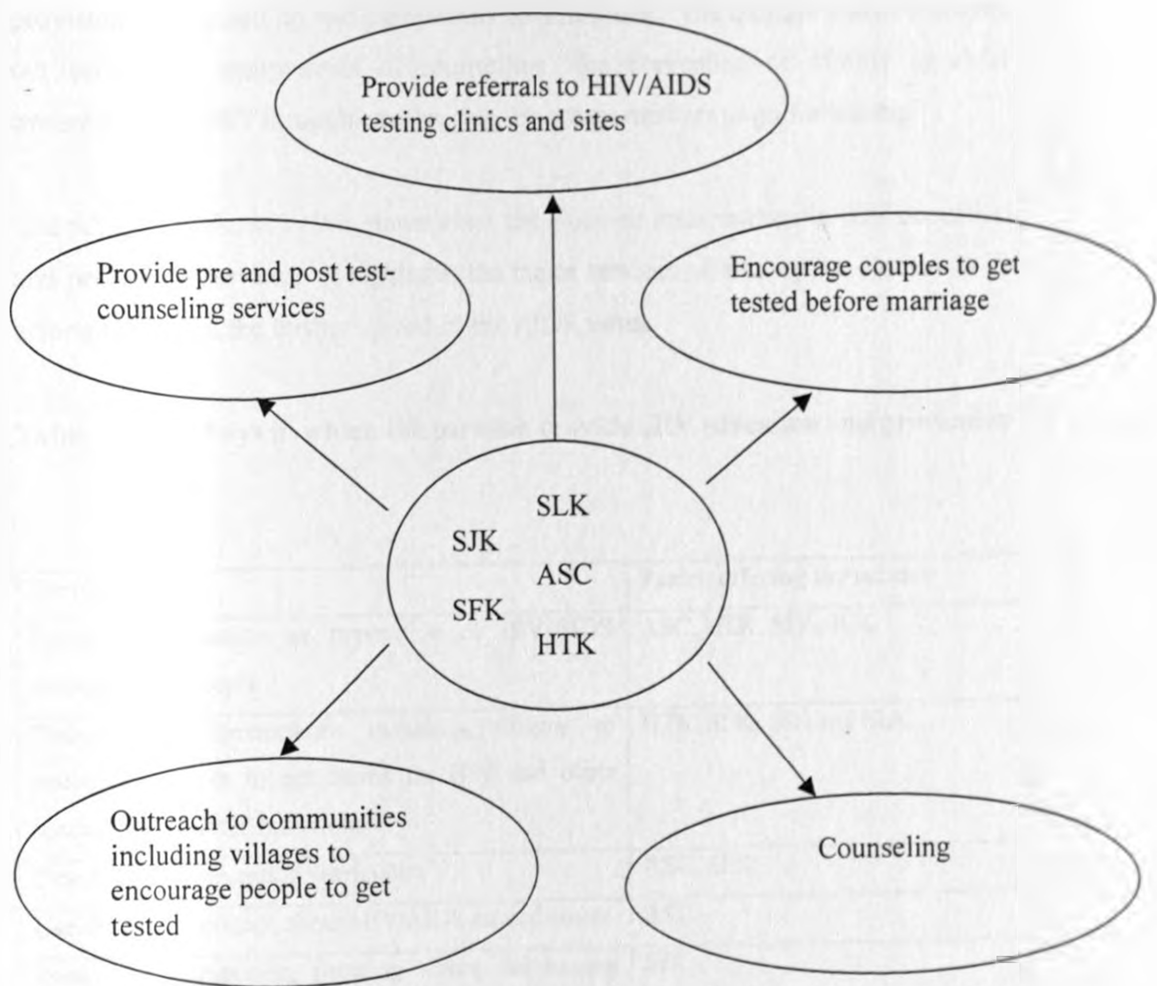
Table 3 below summarizes the activities conducted by All Saints Cathedral parish, St Luke's, Holy Trinity, St Francis, St Joseph and Christ the King. It presents the services offered by each parish and the time frame in which the service has been provided.

Table 3. Type of Activities carried out in the various parishes

TYPE OF ACTIVITY	ASC		SLK		HTK		SFK		SJK	
	Service offered	Duration	Service offered	Duration	Service offered	Duration	Service offered	Duration	Service offered	Duration
HIV education and Prevention	√	4yrs	√	3 months	√	2yrs			√	3yrs
HIV counseling	√	"	√	"	√	"	√	1yr	√	"
Outreach services	√	"	√	"	√	"	√	"		
AIDS surveillance	√	"	√	"	√	"	√	"		
Orphan support			√	"			√	"	√	"
Referral for HIV testing	√	"			√	"	√	"	√	"
AIDS policy development					√	"	√	"		
Spiritual counsling	√	4yrs			√	"	√	"	√	3yrs
Bereavement support for families	√	"			√	"	√	"		
Awareness creation during services	√	"								
Technical support to AIDS organizations							√	1yr		
Diagnosis treatment of tuberculosis and sexually transmitted diseases					√	2yrs				
Use of the bible/pulpit to influence behavior change	√	4yrs								

The figure below indicates some of the ways in which the parishes provide HIV testing and counseling. It was noted by the researcher that none of the parishes in the diocese provide HIV testing services. Much of what is done is counselling parishioners and other members of the immediate community on HIV/AIDS and encouraging them to seek testing services in the nearest VCT centres.

Fig. 3. Ways in which the Parishes provide HIV testing and counseling



One major strategy employed by the Kenyan government in the fight against HIV/AIDS as noted in the literature is need for every individual to know ones HIV status. This is the first step in preventing further spread of the virus. It however emerged from the study that the diocese has not ranked testing as a priority in its

emerged from the study that all the Parishes in the diocese have not put testing as a priority among their interventions. This is however as a result of the gap in qualified staff who can conduct the testing. All the parishes in the middle circle are conducting similar activities in place of HIV testing and counselling.

This figure therefore proves the situational approach theory in terms of how communities or individuals respond to a challenge that they do not have a forth-coming response. The parishes tend to respond to the challenge in a routine manner since one of the key responsibilities of the church is providing spiritual counselling. It can thus be deduced that a major response by the diocese and the parishes is provision of counselling and outreach to communities. The diocese however leaves out other vital components of counselling like Prevention of Mother to child transmission of HIV through encouraging expectant mothers to go for testing.

The table that follows below summarises the dioceses interventions in HIV education and prevention services. It highlights the major services offered by the diocese in its efforts to prevent the further spread of the AIDS virus.

Table 4. Ways in which the parishes provide HIV education and prevention services

Service offered	Parish offering the service
Focus on education an prevention of HIV/AIDS among young people	ASC, HTK, SFK, JLK
Outreach to communities including villages to encourage people to get tested for HIV and other sexually transmitted infections	HTK, SFK, SJK and SLK
Develop HIV prevention curriculum	ASC, SFK
Use the pulpit to teach about HIV/AIDS related issues	ASC
Preaching, dramatising, showing videos and having PLWHA's testifying before the congregation	SJK
Hold workshops/seminars in collaboration with doctors from KNH	SLK

According to the All Africa Anglican planning framework, one of the strategies in the fight against HIV/AIDS is prevention of the further spread of the virus that causes AIDS. The researcher has thus deduced that one major strategy employed by the Anglican Church of Kenya is the pulpit ministry, which involves preaching about abstinence and being faithful to partners for the married.

This strategy however has its own set backs in that if the pastors are not fully aware about the modes of transmission of the virus as well as the meaning of stigma, they could be chasing people out of their churches due to the methods used in preaching their sermons. This is also compounded by the absence of sample sermon guidelines for the pastors in the diocese. Furthermore, the absence of HIV/AIDS policies does not make the congregations welcoming for people living with HIV/AIDS.

4.3 CHALLENGES FACING THE ACK IN ITS INTERVENTION EFFORTS

The study unveiled some challenges that hinder the All Saints diocese in its HIV/AIDS interventions. These challenges were outlined by respondents from the MU and KAMA during the FGD's. The literature review section highlighted some challenges faced by the church. This section expounds on the un documented challenges in the literature.

The following are issues hampering the intervention efforts: -

(i) **Information flow** from the Province to the Parishes is lacking. A member of the MU commented, "The lack of centres for information dissemination means parishioners must come to the headquarters, this involves transportation which members are not willing to sacrifice".

(ii) **Inadequate finances** hamper movement of parishioners to seek information from the concerned offices, to attend seminars/workshops. A member of KAMA commented that;

Initially people were paid once they attended a workshop but there day there is 'nothing' so people do not want to come to workshops, they term it as 'time wasting and costly'.

(iii) **The big size of All Saints Diocese**, which is also a cosmopolitan and composed of people with different levels of academia and status, makes it difficult to reach out to the members. A member of KAMA said, "They are not willing to participate in the fight against HIV/AIDS".

(iv) **The diversity of communities** living around the diocese play a major role in these intervention efforts for instance a respondent commented;

Ethnicity today is much stronger in Kenya than ever before. For example, in training or awareness creation in certain areas it becomes difficult deciding whether to use Kikuyu or Luo as a facilitation language especially in the case of Holy Trinity Kibera. People have not broken these boundaries and created inter links in the various aspects of life instead tribalism is becoming stronger and is being used to fuel animosity and selfish gains.

(v) **Ownership of the HIV/AIDS programme** at the Parish level is lacking. The method of Top-Down approach to HIV/AIDS issues by the Church has failed, as information; goods and services have not trickled down to beneficiaries to a noticeable level.

(vi) **Stigma** is not only a problem originated by the laypersons but also by the Church including the clergy who are supposed to give direction on HIV/AIDS to congregations. A member of the MU commented that;

The Church still passes judgmental remarks on victims of HIV/AIDS, they are viewed as people with loose morals and unworthy of God's Kingdom yet the Church should be their refugee to shield them from psychological torture, unworthiness, mistreatment and starvation among others.

(vii) There is a general **lack of dedication** to the program, as members no longer attend meetings when called upon. A KAMA member commented that;

Instead they would rather use this time to attend social gatherings, transact businesses, and rest in their homes. In fact our elders, parents, grand parents need to go back to the roots and take up HIV/AIDS issues more seriously because it is the young generations which are being wiped out. Dedication to this cause amongst the congregations should begin at family level.

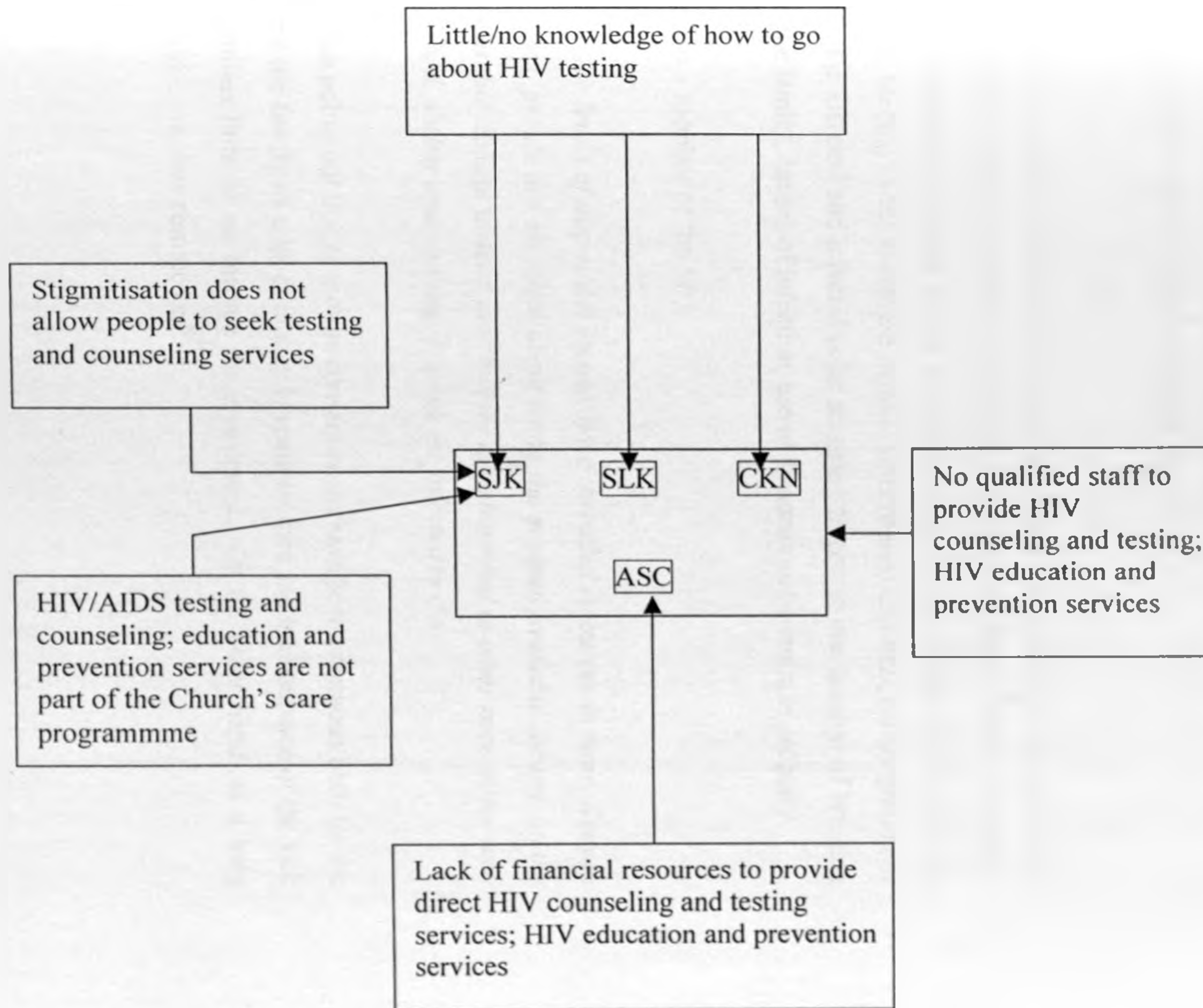
(Viii) **Lack of qualified personnel** trained in HIV/AIDS ministry in the parishes. The insufficient number of clergy trained in HIV/AIDS cannot allow for the proper management of the programmes.

(ix) **Lack of initiative by the clergy** means very few projects have been started and continue to operate. The respondents commented, "Members of KAMA, MU, Youth and Sunday school teachers are waiting for somebody to give direction instead of spearheading it themselves".

(x) **An inter ministerial pool** is non existent as such a pool would lead to the formation of a core committee co-opting members from other ministries for the purpose of collecting, collating, activating and disseminating information on HIV/AIDS activities.

The research revealed that there exist some challenges as the church initiates interventions in the fight against HIV/AIDS. Some of the challenges are however due to rhetoric's by the church leadership and members. This is compounded by the absence of a functional committee and diocesan strategy and HIV/AIDS policy that is people directed through the bottom up approach. The table below summarizes the challenges specifically linked to provision of HIV testing and counseling, education and prevention services in the diocese.

Fig 4. Barriers to providing HIV Testing and counseling; education and prevention services



From the above figure, the researcher concluded that, Holy Trinity Kibera faces one major challenge, which is the lack of financial resources to provide direct HIV counseling and testing, and HIV education and Prevention services, this is common in all the Parishes. However, little or no knowledge of how to go about HIV/AIDS testing is a challenge faced by St Joseph, St Luke's and Christ the King. Stigimatisation does not allow PLWHA's to seek testing and counseling services at St Joseph parish at the same time the members interviewed reported that HIV testing and counseling; education and prevention services are not part of the core programme.

4.3.1 Consequences of the identified challenges

According to the qualitative data generated by the study, the effects of the identified challenges namely; inadequate finances, lack of commitment, stigma, ethnic diversity, insufficient information among others have led to the continued loss of lives to the killer disease leading to the increased number of orphaned children, disintegration of families as the affected and infected point accusing fingers to one another of bringing shame to the family, causes of infection, use of finances and interest in property.

According to a member of the MU;

> *The low levels of disposable income have dwindled resources in many Kenyan homes, people are skeptical about using the minimal available income on the incurable disease instead such monies are channeled to other necessities such as food, shelter and clothing, leaving the infected to die.*

The data also points out that economic consequences have been enormous both for the country and the family as a lot of money is spent on care and maintenance of the sick leaving families little or no income for investment. On the other hand, as a long serving KAMA member commented;

The government devotes lots of resources to addressing HIV/AIDS for instance, in creating awareness, provision of anti retroviral among others. Such monies could otherwise have been re-directed into investment ventures to generate more income. This leaves Kenyans poorer than ever before.

The data also revealed that the Clergy are not comfortable discussing HIV/AIDS issues, and since the PLWHA's are stigmitised, many resort to keeping to themselves or embark on an aggressive programme of spreading the disease. The diocesan HIV/AIDS coordinator (a pastor) commented that;

Whichever is the case both situations are dangerous, the former leads to loss of hope, hatred, mental torture and premature death while the later leads to scores of other people getting infected. When the right information is not disseminated wrong messages are conceived. For instance, the affected have been turning up at the Cathedral in big numbers expecting to receive money.

Many of the challenges have not been addressed due to the centralization of the programme.

Overall, the HIV/AIDS programme so far has no impact because members are not aware about the existence of the diocesan HIV/AIDS initiative as well as due to lack of organizational capacity at Church level. Furthermore, there is no interaction and inter-change of ideas on HIV/AIDS programmes as a result there is a gap in sharing experiences with other Dioceses. The few activities which have been initiated, for example creating awareness in primary and secondary schools, churches, visiting homes of the infected and affected giving home based and pastoral care, counseling among others have been going on basically in a few parishes. However, the biggest obstacle in the diocesan HIV/AIDS initiative is the lack of finances. As a committee member from St Francis said:

In some instances you come across victims who are starving, who have absolutely nothing and you are forced to give from your pocket. The infected have been left to the mercy of those who have compassion whereas this should be a duty for the Church.

4.4 Contribution of Mothers' Union and KAMA to the Church HIV/AIDS Activities

The study collected qualitative data from the FGD's conducted for MU – the care and support arm of the church- and KAMA. What follows is the analysis of the information gathered during the discussions. According to the respondents in the FGD's, there is minimal activity in as far as HIV/AIDS programmes initiated and sustained by the Church.

St. Francis Karen exhibited some activity. All the above groups are involved in visiting the sick, fund raising including church contribution towards the programme through the provision of finances, pastoral care and counseling. No tangible evidence exists of HIV/AIDS Programmes initiated and sustained by the Church. The chairperson of the Parish HIV/AIDS committee who is also a member of the MU in the parish commented that;

> *In our parish, the men of St Francis show films and have open indoor discussions on HIV/AIDS issues. The MU visit the sick in the community and provide food as well as spiritual nourishment.*

In this particular parish, the members opt not to call themselves KAMA but 'men of St. Francis'.

At the All Saints Cathedral parish, KAMA has not yet gotten involved in HIV/AIDS interventions. As one KAMA member responded during the FGD's;

> *Never in KAMA meeting have we deliberated on HIV/AIDS issues...KAMA is not even represented in the HIV/AIDS programme let alone other groups.*

Some members of the M.U and KAMA are counselors, doctors, sociologists, teachers and have been willing to offer their services to the infected and affected through provision of medical care, counseling, training, however, according to the FGD's, they have not been called upon. The study also revealed that many of the FGD participants were retired from the civil service and are willing to assist as long as programs are identified. This indicates that most of the working class members of the church are not fully involved in church activities especially HIV/AIDS.

It is evident from the data that the MU is more active in the provision of services in the diocese as compared to KAMA. However, there still remains an untapped human resource in the parishes, which if fully brought on board could enhance the response of the two church groups in the fight against HIV/AIDS.

The study revealed that the church groups do not fully participate in the interventions due to lack of a coordinating body and strategy. As a KAMA member from Kibera said;

We need more focused efforts to reach the people properly

Due to the absence of a coordinated strategy, the church groups have not mainstreamed HIV/AIDS into their activities and have not acted spontaneously to initiate or bring their members together for HIV/AIDS discussions. This was evident during the FGD with the MU who had some of their members as part of the diocesan committee but had not called their constituency to share the out comes of the committee meetings and deliberations. The flow of information is also absent among the church groups themselves leaving the majority of the members out of the loop in the fight against HIV/AIDS.

4.5 MEMBERS PERCEPTIONS TOWARDS THE HIV/AIDS PROGRAMMES IN THEIR PARISHES

The study endeavoured to highlight the member's perceptions towards the HIV/AIDS interventions initiated by their parishes and the diocese as a whole. The data revealed several perceptions especially in line with what the HIV/AIDS desks should entail.

The respondents from the MU perceived the interventions currently being implemented by the parishes as inadequate and wanting due to the lack of ownership and commitment by all stakeholders (members and leaders). One of the MU members commented;

> *In a situation where people should volunteer their services and time, no one is willing to do so. Instead people hear the call for assistance but dismiss it and to say the least HIV/AIDS is still an abstract idea. People are not keen about those dying of the disease until a close relative dies, that is when it hits them that this epidemic is real.*

The programmes are therefore viewed as interventions initiated by people who are either themselves living with or personally affected by HIV/AIDS and not as a response to a social, spiritual and economic challenge.

Some respondents reported that there was lack of commitment in both those who are already involved in the HIV/AIDS programme and those who are supposed to be involved (especially those with remote knowledge of the programmes). One participant commented that;

> *People are involved in other activities in their parishes so much so that they do not have time for the HIV/AIDS programme especially when they have not been called upon to participate.*

Another participant commented;

People these days are not willing to participate unless there is monetary gain, once no money is trickling into individual pockets, and then people are less concerned.

Other respondents including MU, KAMA and the vicars, felt that the stigma which has been adopted by even clergy, gives a negative impression to the members of the congregation who may withdraw their willingness to work with the infected or contribute towards provision of goods and services meant to improve the lives of such persons. A pastor in one of the FGD's commented that;

The clergy who are living with HIV should be positive about their disease and reflect this on their congregations in order to change perceptions.

Furthermore, the rural dean/vicar of St. Luke's commented that;

Faith communities should destigmatize HIV/AIDS by offering loving care to those who are inflicted. Consequently financial assistance to achieve that goal is crucial.

It can therefore be deduced from the above that the members perception of the interventions are based on what they observe in their parishes as well as what is missing in the interventions. It is the members perception that stigma continues to hinder the response of the church in the fight against HIV/AIDS. The interventions lack financial allocations for the diocese to conduct its work effectively. Furthermore, members of the church are pre occupied by other parish activities that they do not give precedence to mainstreaming HIV/AIDS into their activities.

Another perception that can be deduced from the above data is that the church mainly relies on volunteer services where as the members expect some incentives to boost their morale as they participate in the interventions. Another strong perception is that HIV positive clergy are not coming out to disclose their status to the members hence people living with HIV/AIDS lack the support mechanism they look for in the church.

All the respondents were of the view that finances play a major role in determining the type of interventions that a parish can initiate. The respondents commented;

Financial resources bring to a half even conceived ideas towards helping the ailing, orphans and families affected by the scourge because funds are required to facilitate communication, provide the much needed goods and services, facilitate training e.t.c.

The respondents also perceive the interventions as not effective due to lack of capacity in terms of staffing and office space. KAMA respondents commented that;

KAMA for instance, lacks an office to run its affairs let alone the introduction of additional programmes.

4.6 EFFECTIVENESS AND SUSTAINABILITY OF THE ACK HIV/AIDS INTERVENTIONS

According to the findings, for the programme to be effective and sustainable there has to be good will as well as adequate resources to run the HIV/AIDS programme, which is one of the reasons why many Parishioners and the public are not aware of the Provincial and Diocesan HIV/AIDS desks. Furthermore, the diocese is currently not in apposition to sustain the HIV/AIDS interventions because as an MU member commented;

The idea has not been entrenched in the minds of the parishioners in order for them to keep contributing financially and in kind to a kitty to be used to facilitate the intervention.

A member of the St Francis HIV/AIDS parish committee commented that;

The Provincial HIV/AIDS office and the government should channel a large portion of the HIV/AIDS funds through the church. All churches in this country, community based organizations, local NGO's, women groups among others.

The members have already registered their committee as a CBO and this would ensure sustainability and ownership of the programme if funds from both the church

and government through the HIV/AIDS constituency funds are channeled through the church structures like the parish and diocesan committees.

The art of volunteer service (in terms of skills, time e.t.c.) is lacking as earlier observed due to lack of incentives for members. The diocese lacks proper sensitization about its programme to ensure that all levels of the church structure are conversant with the concepts and interventions for communal sustainability.

For the current and planned interventions to be effective and long term, according to a member of the MU;

> *It is the duty of the Mothers' Union to enhance visitations to the infected and affected, provide skills on home based care, gather and prove the necessary date for future intervention and above all give hope to the victims through prayer.*

KAMA members on the other hand commented that the men in the association;

> *Is not taking up the responsibility of financing the programme through fundraising, sourcing resource persons and peer education while KAYO is not fully concentrating on peer education through song and drama. KAMA and M.U are not acting as role models to the youth to facilitate open talks between parents, grand parents and their children on matters of sexuality in order for the HIV/AIDS interventions to be effective and sustainable.*

The respondents also commented that, the programme is not effective since all church groups including the "Sunday schools are not used as avenues where AIDS issues are discussed and reflected through poems, songs and drama". On the other hand, the Bishops and the Clergy " are not fully involved in soliciting funds and at the same time not designing sample sermons, which teach morals, love and care of the sick and dying thus extend pastoral care to both parishioners and the public".

The members however commented,

The parishioners are also not playing a greater role of contributing financially and in kind towards HIV/AIDS projects. They are not extending brotherly love to the infected and affected within their parishes and communities, not open about HIV/AIDS issues and do not discuss them with all concerned especially the youth.

In order to enhance efficiency and sustainability the members of the St Francis HIV/AIDS parish committee commented;

The church committees should be in the forefront in establishing sensitization activities and mobilization of members and interaction of parishes. The Parish, Diocesan and Provincial HIV/AIDS Coordinators should then help to establish the machinery that will facilitate sensitization and mobilization that will identify activities to be funded and over see their implementation and carry out monitoring and evaluation of the programmes.

From the data generated, the researcher notes that it is important that funds are availed to the various actors to ensure facilitation of communication, training and project implementation, capacity building of these actors and other groups which will be involved in project implementation and sustainability. The various stakeholders understand their role in the implementation of HIV/AIDS interventions, however, communication should be enhanced and monitoring and evaluation carried out regularly to ensure that the beneficiaries are receiving the much-needed assistance and that the members own the day-to-day running of the parish activities.

The study also reveals that the church's interventions cannot be effective if all stakeholders are not included in the formulation and implementation of the interventions. Furthermore, the church so far can only sustain a few programmes namely, pulpit ministry since that is a routine practice by the clergy, counselling, outreach programmes and referral for HIV/AIDS testing since these do not require any forms of direct funding to be carried out but however depend on volunteer services which are not available due to lack of incentives.

CHAPTER FIVE

5.0 SUMMARY, IMPLICATIONS, RECOMMENDATIONS AND CONCLUSION

5.1.0 SUMMARY OF FINDINGS AND IMPLICATIONS

The study has found out the following regarding the response of the Anglican Church of Kenya in the fight against HIV/AIDS in the diocese of All Saints. One, there is little knowledge about the HIV/AIDS desks at provincial and diocesan level. Two, some of the programmes initiated in the parishes, include counseling, HIV education and prevention, outreach services, orphan support, referral for HIV testing, spiritual counseling, bereavement support for families and awareness creation. Three, challenges faced by the church include, information flow to all levels, inadequate finances, the big size of the diocese, the diversity of communities in the diocese, ownership of the programme, stigma, lack of dedication, lack of qualified personnel, lack of initiative by the clergy and lack of an inter ministerial pool. Four, consequences of the challenges outlined, which include increased numbers of people getting infected as well as socio-economic implications. Five, contribution of members namely MU and KAMA to the fight against HIV/AIDS in the diocese. Six, member's perceptions towards the interventions and seven, the effectiveness and sustainability of the diocesan interventions strongly depends on ownership, good will by members and leaders, continued flow of funds through the set church structures and enhancement of volunteerism.

Deducing from the above highlighted issues, it is evident that the HIV/AIDS programme has not been entrenched in church activities or as a church activity. A lot therefore needs to be done as far as sensitization and mobilization is concerned. All activities should be community initiated if the programme is to attain sustainability. The community (parishioners) should contribute towards the management of the programme in terms of finances, time, skills and any other material and moral support. The HIV/AIDS desks at the Provincial, Diocesan and Parish levels should act as guides/enablers in the process.

The implications of the findings are that the church will continue to be perceived as idealistic and less involved in practical solutions in the fight against HIV/AIDS. As AIDS activists during the 2003 ICASA conference lamented "you talk we die" the ACK is faced with the challenge of shifting from meetings and discussions to implementation of viable and sustainable programmes that indicate people level impact in terms of transforming communities to be receptive to people living with HIV/AIDS, eradication of stigma and prolonging the lives of people living with HIV/AIDS through the provision of testing facilities, treatment and nutrition programmes.

5.1.1 RECOMMENDATIONS

Based on the findings from the qualitative data gathered in this study, the following are some of the recommendations put forward by the researcher.

The major gap that needs to be filled is the development of an HIV/AIDS policy that will guide the diocese in eradicating stigma and discrimination and how to respond the epidemic.

According to the respondents, as a member of KAMA put it, "Communication from the Provincial level to the Diocese and to the Parishes should be superb, regular and fast, and so should the level of awareness created by those participating in the programme if they have to reach out to the parishioners and *'break the wall of integrity'* by making known that AIDS is real".

There should be thorough training of the persons who are involved in the HIV/AIDS programme at the various levels. Capacity building is very important – this needs to be facilitated by resourceful people in the area of HIV/AIDS. This means more training for the Trainer of Trainers (TOT).

The view of some respondents was that the Diocese and the various ministries under it, the M.U, KAMA, KAYO should be networked and the AIDS Program brought on

Board to avoid duplication. This also applies to networking with other organizations involved in HIV/AIDS work.

The M.U and KAMA made it known that they have not been involved and since it is not part of their objectives, they cannot participate without invitation and yet the only way to tackle this epidemic is by involving as many as possible. There is need for proper organization and training of members if any substantial results are to be realized.

Prevent the rampant spread of HIV/AIDS and provide care and support to the infected and affected

Facilitate training programmes for the Church personnel handling AIDS issues within the various ministries and ensure more training for the TOTs.

Solicit funds for the programmes initiated in the various parishes and the lower levels thus Diocesan and Parish desks should be allowed to solicit funds parallel to the provincial office.

Sensitize and create awareness on HIV/AIDS programmes. The men in KAMA need to be brought on board very keenly and cautiously by articulate resource persons if they are to participate fully in the fight against HIV/AIDS.

Create an inter link amongst the 35 ministries of the Church with HIV/AIDS programmes introduced into each ministry where appropriate.

The office of the people's warden should identify persons to be enrolled in service training to deliver the required service.

The members should establish centres to be manned by experienced personnel (preferably sociologists) to run the HIV/AIDS issues. They can also fix a day for make shift centres to avail services and goods to people living with or personally affected by HIV/AIDS. Such centers should be on the forefront in facilitating home

visitations for the purpose of prevention of family disintegration by sharing the love of Christ.

The Church should allocate a budget to the HIV/AIDS programmes for it to meet expenses of transport, provision of foodstuff and medicine, hiring of resource persons among other requirements needed to realize success in the implementation of the programme.

The Church through the above groups should adopt an aggressive strategy of raising funds both internally and externally to be able to fund the programme instead of depending on the Provincial HIV/AIDS office. They need to mobilize resources within the community, appeal for donations from businesses. A committee should be appointed to specifically oversee the implementation of the activities of this programme.

Without an office specifically for the coordination of HIV/AIDS issues both at the Diocesan and Parish levels, much cannot be achieved as there is a clash of interests with those who head other Church programmes and own offices. It is difficult for 2 ministries to operate from the same office. On the other hand, the HIV/AIDS ministry should be incorporated into the other Church programmes and taken up by different associations within the Church for example, the M.U, KAMA, KAYO e.t.c.

5.1.2 CONCLUSION

The study sought to assess the response of the Anglican Church in the Diocese of All Saints in fight against HIV/AIDS. Interest from this study was as a result of the gap identified in the literature inline with documentation and assessment of religious groups responses to HIV/AIDS in Nairobi. Moreover, existing studies that have been conducted elsewhere have not focused on the response of ACK in the fight against HIV/AIDS. The study is therefore the first to assess and document the response of the ACK in the All Saints diocese in the fight against HIV/AIDS.

The study attempted to answer the following research questions;

1. What is the ACK's capacity in tackling challenges of HIV/AIDS?
2. How effective and sustainable are the ACK strategies for fighting HIV/AIDS?
3. What are the perceptions of the members towards the HIV/AIDS programmes initiated by the ACK?

The research fitted within the framework of the situational approach theory, which seeks to explain human behaviour displayed in trying to correct an abnormal circumstance. The theory assumes that human behaviour occurs when there is an experience affecting the definition of individuals and groups, their behaviour and influencing the situation and personality as well as changing the direction of situation. It is also, assumes that the efficiency in the definition of the HIV situation depends on other factors such as psychological, spiritual, information access, social influences and experience among others. The approach is widely used in social sciences in explaining human behaviour.

The study has recommended that several steps needs to be taken by the diocese in order to effectively make an impact in the fight against HIV/AIDS. Some of the recommendations include setting up of parish HIV/AIDS committee comprising of all the church groups namely; Sunday school, youth, MU, clergy and KAMA, which will in turn mainstream HIV/AIDS in their respective fields.

The study has however concluded that, the diocese has made little or no impact in the 6 parishes assessed in its fight against HIV/AIDS due to the absence of people level impact at the grass roots level as well as the full participation of members in the assessment, planning, design and implementation of the current activities. A major set back identified by the study is the lack of HIV/AIDS policies at diocesan and parish levels as well as an HIV/AIDS strategic plan at the provincial and diocesan level. Therefore, the efficiency and sustainability of current and future interventions depends on the levels of ownership, willingness by members and leaders, availability of funds and community mobilisation in eradicating stigma and discrimination in

order to have more people going for HIV/AIDS tests and hence preventing further spread of the virus that causes AIDS.

5.1.3 Areas of further research

1. The response of the Church in HIV/AIDS treatment preparedness – treatment literacy; care, support and treatment continuum (comprehensive care includes the following basics: diagnosis, treatment, referral and follow up, nursing care, counseling, support to meet psychological, spiritual, economic, social and legal needs

2. HIV/AIDS related Stigma in church institutions specifically analyzing the contribution of church leaders to the increase of stigma

3. An assessment of the policy on the Holy communion cup in line with prevention measures taken by religious institutions like the ACK

4. The measures put in place by religious organizations in the promotion of abstinence as a strategy in preventing HIV/AIDS

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APPENDICES

APPENDIX 1: FOCUS GROUP/ INTERVIEW DISCUSSION GUIDELINES

For discussions with the FGD's composed of the following:

FGD participants	Holy Trinity	All Saints	St. Francis	St. Lukes	St. Stephens	Christ the King
Mother's Union (MU)						
Kenya Anglican Men's Association (KAMA)						
HIV/AIDS Parish committees						

Assessment of impact of the ACK HIV/AIDS programme in the

Diocese of All Saints

Section 1: knowledge on the Provincial and Diocesan HIV/AIDS desks

This section attempts to establish how much is known about the ACK provincial and diocesan HIV/AIDS desks by parishioners in the selected parishes. We are therefore attempting to answer the question: how well informed are the Christians and leaders of the Anglican Church about the HIV/AIDS interventions by the Church? To obtain the information required, explore the following questions:

1. Are you aware of the Provincial and Diocesan HIV/AIDS desk? Please explain

2. If you know about the desks, please narrate how you came to know about them?

3. What do the HIV/AIDS desks entail?

4. What do you consider to be the goal(s) of the HIV/AIDS desks?

Section 2: challenges facing the ACK in its intervention efforts

Under this section, we would like to know the general views of parishioners about the challenges facing the Anglican Church in its interventions programmes at Diocesan and Parish level. Kindly explore the following questions:

1. What have been the challenges your parish has faced in setting up HIV/AIDS projects/programmes? From Parishioners? The Diocese? Public? Etc. and what have been the consequences of such challenges?

2. Have such challenges persisted or have they been tackled? Please explain

3. What would you say of the programmes currently in place in your Diocese/Parish after the introduction of the ACK provincial and diocesan AIDS desks?

4. What factors explain why some parishes have not initiated HIV/AIDS programmes?

5. What are members (your group – i.e. Mother's Union/ Kenya Anglican Men's fellowship, youth, Sunday School) contributing to the church HIV/AIDS activities?

6. Can you identify any issues that hinder the effective running of the HIV/AIDS programmes/projects? Can you suggest how they can be addressed?

Section 3: effectiveness and sustainability of the ACK HIV/AIDS interventions

Given the numbers of people currently living with HIV/AIDS in Kenya and the increasing numbers of orphans, the reality of sustaining and the HIV/AIDS programmes by the Anglican Church is quite a challenge. This section attempts to review how the ACK HIV/AIDS interventions are being implemented and sustained.

The specific objective of the section is to establish whether the parishioners were and are aware about the implementation activities of the HIV/AIDS programmes initiated by ACK at Provincial/diocesan and parish level. To reach this objective, explore the following questions:

1. Do you think the church has adequate resources to make the vision "that future generations will be born and live in a world free from AIDS" a reality?

2. Is the church able to sustain the AIDS interventions?

3. Besides the Provincial and Diocesan HIV/AIDS desks, who else should be involved in making the interventions successful?

4. More specifically what roles and responsibilities should the following actors play to make the interventions more effective:

   - The various church groups – MU, KAMA, KAYA and Sunday school
   - Bishops', clergy
   - Parishioners
   - Church committees
   - Parish, Diocesan and Provincial HIV/AIDS coordinators

5. How can the capacities of these actors be increased to boost their contribution in making the HIV/AIDS interventions more effective?

6. In general, do these stakeholders understand their role in the implementation of the HIV/AIDS interventions? If not, how can they be brought on board?

Section 4: Member's perceptions towards the HIV/AIDS programmes in their parishes

This section aims at getting your views regarding the activities/projects in place in the All Saints diocese and your Parish. To obtain the required information for this section, explore the following questions:

1. In general, would you say that Christians in the diocese were/are optimistic or pessimistic about the success of HIV/AIDS interventions in the diocese/parish?
2. What are the leading HIV/AIDS intervention achievements of the Anglican Church?
3. What are your experiences with the HIV/AIDS programmes/activities/projects over the last 12 months? And how satisfied are you with the existing interventions? Please explain
4. What can you say about the process of implementation of the HIV/AIDS projects/activities etc?
5. What aspects of the ACK HIV/AIDS programme intervention is strong? What aspects are weak?
6. How can the weak aspects be addressed?
7. What suggestions do you have to make the HIV/AIDS interventions successful in the future?

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